

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>30 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>15614 OAK PLACE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WINBERN</u> Middle <u>C.</u> Last <u>ADCOCK</u>				4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-78</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Adcock</u>				14. MOTHER'S MAIDEN NAME <u>NANNIE PARRISH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>SPANISH AM.</u>				16. SOCIAL SECURITY NO. <u>SON. 3517 K HOM Rd. Balto 7. Md.</u>			
17. INFORMANT <u>Francis N. Adcock</u> Address <u>Balto 7. Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 WKS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.							
22. ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Leo J. Oonnuvan M.D.</u>				<u>2/17/59</u>			
PHYSICIAN'S NAME (Type) <u>LEO J OONUWAN M.D.</u>				<u>Bethesda 14 Mo</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>2/20/59</u>		<u>Glenwood Cemetery</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>St Hines Co 2901 14 St NW</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page One of One

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. MARITAL STATUS [REDACTED]		7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]		10. PLACE OF DEATH [REDACTED]	
11. DATE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]		13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF PHYSICIAN [REDACTED]	
16. SIGNATURE OF REGISTRAR [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF JUDGE [REDACTED]		19. SIGNATURE OF SHERIFF [REDACTED]		20. SIGNATURE OF CORONER [REDACTED]	

2019
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>116 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. STREET ADDRESS <u>5812 Sargent Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Michael</u> Last <u>Alexander</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1950</u>	
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wilmer</u> Werner <u>Alexander</u>				14. MOTHER'S MAIDEN NAME <u>Raffella Melina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenocortical Carcinoma, Metastatic</u> <u>1950</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 8, 1958</u> , to <u>February 1, 1959</u> , that I last saw the deceased alive on <u>February 1, 1959</u> , and that death occurred at <u>3:18 a. m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>2-1-59</u>			
PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Collins</u> ADDRESS <u>WASH. D. C.</u>				24a. REC'D BY REGISTRAR <u>DATE B 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	
FRNACIS J. COLLINS 3821 14TH. ST. N.W.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01991

2020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 60 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 4104 Dresden Street			
3. NAME OF DECEASED (Type or print) First John Middle Relyea Last Appleman				4. DATE OF DEATH Month February Day 13 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1924	
9. AGE (In years lost birthday) 34 yrs.		IF UNDER 1 YEAR Months 34		IF UNDER 24 HRS. Days 34		Hours 34 Min. 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Conditioning Installer Air Conditioner				10b. KIND OF BUSINESS OR INDUSTRY District of Columbia		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Lawrence V. Appleman			
14. MOTHER'S MAIDEN NAME Margaret Cogan				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War II Unascertainable			
16. SOCIAL SECURITY NO. The Medical Record				17. INFORMANT The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 201X DUE TO (c) 201X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 201X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from December 15, 19 58 , to February 13, 19 59 , that I last saw the deceased alive on February 13, 19 59 , and that death occurred at 5:00 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Richard Lee M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) G. Richard Lee, M. D.				DATE SIGNED 2/13/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 2/13/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) Suitland, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS		24a. REC'D BY REGISTRAR FEB 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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2021

CERTIFICATE OF DEATH

01992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 74 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16x-2			
d. STREET ADDRESS 601 Southern Avenue, S. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Monda Middle Aliene Last Aycoth				4. DATE OF DEATH Month February Day 6th , Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 24, 1915	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Ashe				14. MOTHER'S MAIDEN NAME Lula Rodgers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-30-4077		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma Metastatic to Heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 Months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 24, 19 58 , to February 6, 19 59 , that I last saw the deceased alive on February 6th, 19 59 , and that death occurred at 7:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/6/59							
ACTUAL SIGNATURE G. Richard Lee M.D. The Clinical Center							
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/9/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION (City, town, or county) (State) Switzland Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. Wm Lee's Sons Co				ADDRESS 300 4th St Wash 2 Dc. 7 E.		24a. REC'D BY REGISTRAR DATE FEB 10 '59	
				24b. REGISTRAR'S SIGNATURE Wm L. Harris			

01993

2022

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Northampton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Evelyn Middle Claudia Last Bailey				4. DATE OF DEATH Month February Day 21 Year 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1936	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Labor (Private)	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Elijah Collins				14. MOTHER'S MAIDEN NAME Alberta Gillis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-48-1931		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease (c) Hypertensive Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH 4 months 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 18, 19 59 to February 21, 19 59 , that I last saw the deceased alive on February 21, 19 59 , and that death occurred at 10:15 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis Gillespie, Jr.				M.D. The Clinical Center		DATE SIGNED 2/22/59	
PHYSICIAN'S NAME (Type) LOUIS GILLESPIE, JR. M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 22, 19 59		22c. NAME OF CEMETERY OR CREMATORY Arlington Va		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Chun				ADDRESS Arlington Va		24a. REC'D BY REGISTRAR FEB 24 59	
24b. REGISTRAR'S SIGNATURE William S. Hanks							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 243 5-26-59 ams
1987
CERTIFICATE OF DEATH

00749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2712 Spencer Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Eliza</u> Last <u>Bean</u>				4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1867</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Ana E. Warfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Washington Sanitarium & Hosp. Records</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis and</u> DUE TO (c) <u>Fracture of rt hip</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell to the floor in her home. Lost her balance.</u>					
20c. TIME OF INJURY Hour <u>8</u> a.m. <u>about</u> p.m. <u>2-1-59</u> 19 <u>59</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In home</u>	20f. (City or town) <u>Ch. Ch.</u> (County) <u>Montg.</u> (State) <u>Md.</u>				
21. I certify that I attended the deceased from <u>Feb 1, 1959</u> , to <u>Feb 2, 1959</u> , that I last saw the deceased alive on <u>Feb 2, 1959</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter K. Angevine</u>				ADDRESS (Street, city or town, state) <u>6300-13th St, NW, Wash. D.C.</u>		DATE SIGNED <u>2/3/59</u>	
PHYSICIAN'S NAME (Type) <u>Walter K Angevine</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>7557 Wain Ave Beth</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

739

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01994

1988

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtons ville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>O.</u> Last <u>Beasley</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-86</u>		9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sight Seeing Guide</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edward Thomas Beasley</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Kenneth W. Beasley - Son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed in auto while driving</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FLANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burtons ville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canaleason, Laurel Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEPARTMENT

A. P. Smith

MEMORANDUM

1982

12

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *A. P. Smith*

2. Date of Death: *12/12/82*

3. Place of Death: *Home*

4. Age: *78*

5. Sex: *M*

6. Race: *W*

7. Marital Status: *M*

8. Occupation: *Retired*

9. Cause of Death: *Heart Disease*

10. Manner of Death: *Natural*

11. Signature of Medical Examiner: *[Signature]*

12. Date of Certification: *12/15/82*

13. Address of Medical Examiner: *123 Main St, New York, NY 10001*

14. Telephone Number: *212-555-1234*

15. Hospital or Facility: *None*

16. Physician: *Dr. J. Doe*

17. Date of Examination: *12/12/82*

18. Time of Examination: *10:00 AM*

19. Name of Hospital: *None*

20. Name of Physician: *Dr. J. Doe*

21. Name of Nurse: *None*

22. Name of Attending Physician: *Dr. J. Doe*

23. Name of Coroner: *None*

24. Name of Medical Examiner: *Dr. J. Doe*

25. Name of Assistant Medical Examiner: *None*

26. Name of Pathologist: *None*

27. Name of Anatomist: *None*

28. Name of Radiologist: *None*

29. Name of Toxicologist: *None*

30. Name of Forensic Pathologist: *None*

31. Name of Forensic Anthropologist: *None*

32. Name of Forensic Dentist: *None*

33. Name of Forensic Psychologist: *None*

34. Name of Forensic Psychiatrist: *None*

35. Name of Forensic Social Worker: *None*

36. Name of Forensic Nurse: *None*

37. Name of Forensic Investigator: *None*

38. Name of Forensic Scientist: *None*

39. Name of Forensic Analyst: *None*

40. Name of Forensic Technician: *None*

41. Name of Forensic Assistant: *None*

42. Name of Forensic Intern: *None*

43. Name of Forensic Student: *None*

44. Name of Forensic Fellow: *None*

45. Name of Forensic Resident: *None*

46. Name of Forensic Attending: *None*

47. Name of Forensic Professor: *None*

48. Name of Forensic Lecturer: *None*

49. Name of Forensic Consultant: *None*

50. Name of Forensic Advisor: *None*

51. Name of Forensic Observer: *None*

52. Name of Forensic Participant: *None*

53. Name of Forensic Volunteer: *None*

54. Name of Forensic Donor: *None*

55. Name of Forensic Recipient: *None*

56. Name of Forensic Provider: *None*

57. Name of Forensic Consumer: *None*

58. Name of Forensic Producer: *None*

59. Name of Forensic Distributor: *None*

60. Name of Forensic Retailer: *None*

61. Name of Forensic Wholesaler: *None*

62. Name of Forensic Manufacturer: *None*

63. Name of Forensic Supplier: *None*

64. Name of Forensic Vendor: *None*

65. Name of Forensic Contractor: *None*

66. Name of Forensic Subcontractor: *None*

67. Name of Forensic Partner: *None*

68. Name of Forensic Associate: *None*

69. Name of Forensic Affiliate: *None*

70. Name of Forensic Related Party: *None*

71. Name of Forensic Interested Party: *None*

72. Name of Forensic Beneficiary: *None*

73. Name of Forensic Injured Party: *None*

74. Name of Forensic Damaged Party: *None*

75. Name of Forensic Affected Party: *None*

76. Name of Forensic Impacted Party: *None*

77. Name of Forensic Involved Party: *None*

78. Name of Forensic Connected Party: *None*

79. Name of Forensic Linked Party: *None*

80. Name of Forensic Associated Party: *None*

81. Name of Forensic Related Party: *None*

82. Name of Forensic Connected Party: *None*

83. Name of Forensic Linked Party: *None*

84. Name of Forensic Associated Party: *None*

85. Name of Forensic Related Party: *None*

86. Name of Forensic Connected Party: *None*

87. Name of Forensic Linked Party: *None*

88. Name of Forensic Associated Party: *None*

89. Name of Forensic Related Party: *None*

90. Name of Forensic Connected Party: *None*

91. Name of Forensic Linked Party: *None*

92. Name of Forensic Associated Party: *None*

93. Name of Forensic Related Party: *None*

94. Name of Forensic Connected Party: *None*

95. Name of Forensic Linked Party: *None*

96. Name of Forensic Associated Party: *None*

97. Name of Forensic Related Party: *None*

98. Name of Forensic Connected Party: *None*

99. Name of Forensic Linked Party: *None*

100. Name of Forensic Associated Party: *None*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01995

2023

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>230 Huesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Hubert</u>				d. STREET ADDRESS <u>13900 HAMMON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Lucretia Blanchard</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/04</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Amos King</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Johnson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>300-100-1000</u>		17. INFORMANT <u>Robert S. King</u> Address <u>507 Big Foot Lane, Rockville, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive Cardio-vascular disease</u> DUE TO <u>and benign nephrosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>P.P. Andrews</u> M.D. <u>4201 FESSENDEN ST NW 2-16-59</u> PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS MD</u> <u>WASHINGTON DC 2-16-59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01996

2024

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 501 Bonifant St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Craig Lee Boley		4. DATE OF DEATH Feb. 27, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/1948
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. J. Boley		14. MOTHER'S MAIDEN NAME Dorothy V. Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wm/ J. Boley		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral palsy DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Found dead in bed. life
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/27/59	
EXAMINER'S NAME (Type) Frank J Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/2/59	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jula		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR MAR 4 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
DEPARTMENT OF HEALTH - BATHHOUSE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35	
SEX Male		RACE White	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee	
CAUSE OF DEATH Suicide		MANNER OF DEATH Homicide	
DISEASE OR INJURY Gunshot wound of the chest		LOCALITY OF DEATH Memphis, Tennessee	
DATE OF EXAMINATION April 4, 1968		PLACE OF EXAMINATION Memphis, Tennessee	
NAME OF EXAMINER Dr. J. H. Smith		SIGNATURE OF EXAMINER [Signature]	
NAME OF DECEASED JAMES EARL RAY		AGE 35	
SEX Male		RACE White	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee	
CAUSE OF DEATH Suicide		MANNER OF DEATH Homicide	
DISEASE OR INJURY Gunshot wound of the chest		LOCALITY OF DEATH Memphis, Tennessee	
DATE OF EXAMINATION April 4, 1968		PLACE OF EXAMINATION Memphis, Tennessee	
NAME OF EXAMINER Dr. J. H. Smith		SIGNATURE OF EXAMINER [Signature]	

2025

CERTIFICATE OF DEATH

Reg. Dist. No.

01997

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Clagettville	
		d. STREET ADDRESS RFD # 3, Mt. Airy	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susie Viola Bolton		4. DATE OF DEATH Month Day Year Feb. 16 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1891
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Potomac, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Magruder		14. MOTHER'S MAIDEN NAME Frances Ann Mullican	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Address Mrs Raymond Justice, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular-Renal Disease with 442X DUE TO Hypertension. Terminal Congestive Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Failure. Uremia. Pulmonary Edema. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 years 1 month 3 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1950 , to Feb. 16, 1959 , that I last saw the deceased alive on Feb. 16, 1959 , and that death occurred at 7 p. M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 9830 Main Street		DATE SIGNED 2/17/59	
ACTUAL SIGNATURE M. McKendree Boyer, M.D.			
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chin L. Moleman ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR FEB 20 59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

292

Item 21 Film 238 2-18-59 et 2026 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01998

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Lebanon b. COUNTY Beirut c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 X - 1 d. STREET ADDRESS P.O. Box 2648 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michelle Christine Braafladt				4. DATE OF DEATH Month Day Year February 13, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3, 1950	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Casablanca, Morocco	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Casablanca, Morocco		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Braafladt				14. MOTHER'S MAIDEN NAME Yvette Bouchier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic Lymphoma 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 10 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 5, 19 59 , to February 13, 19 59 , that I last saw the deceased alive on February 13, 19 59 , and that death occurred at 10:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathan S. Taylor M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-13-59			
PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-59		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. Dreesma				ADDRESS Arlington 14 Va.		24a. REC'D BY REGISTRAR FEB 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01999

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>208 St. Lawrence Dr</u>			d. STREET ADDRESS <u>1 208 St Lawrence Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Civa Frances Bright</u>			4. DATE OF DEATH <u>Feb 14 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-09</u>		9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance Service Co. N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Anderson</u>			14. MOTHER'S MAIDEN NAME <u>Ira Shugart</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-03-7928</u>		17. INFORMANT <u>Mary Bright (daughter)</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound thru skull</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound</u>			
20c. TIME OF INJURY Month, Day, Year <u>8:10 a.m. 2/14 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-14-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>		(State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond W. Ziska</u>	
23. FUNERAL DIRECTOR'S NAME (Type) <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. RECEIVED BY REGISTRAR <u>FEB 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Haines</u>		DATE _____			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and markings on a medical certificate form. The form includes sections for patient information, medical history, and cause of death.]

1

[Vertical text on the right margin, likely a filing or tracking number, mostly illegible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02000

Reg. Dist. No.

2028

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winey</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>2112 Conn. Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Oberly-Bright</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>93</u>
11. BIRTHPLACE (State or foreign country) <u>Wooster, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Oberly</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Shuckers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumo-Pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u>Family</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 15, 1958</u> , to <u>Feb. 19, 1959</u> , that I last saw the deceased alive on <u>Feb. 18, 1959</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.M. Bird</u>		DATE SIGNED <u>2/20/59</u>	
PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>		ADDRESS (Street; city or town, state) <u>Sandy Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Haubert Sons 1786 Pa. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>

2029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6008 Walhonding Rd. Glen Echo Hgts.</u>				d. STREET ADDRESS <u>6008 Walhonding Road Washington 16, D. C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Belle</u> Last <u>Buck</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1875</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bland Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Jefferson Robinett</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Elizabeth Shannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Walter Lee Williams 6008 Walhonding Road, Glen Echo Heights, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. _____ Month. _____ Day. _____ Year. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>59</u> , to <u>Feb. 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>59</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. P. Ryland</u>				ADDRESS (Street, city or town, state) <u>4400-49 St NW</u>		DATE SIGNED <u>2-6-59</u>	
PHYSICIAN'S NAME (Type) <u>C. P. RYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West End</u>		22d. LOCATION (City, town, or county) (State) <u>Wytheville Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac N. Morris</u>				24a. REC'D BY REGISTRAR <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	
Arlington Funeral Home 3901 North Fairfax Drive, Arlington, Virginia							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

FILE NO. 10

<p>NAME OF DECEASED JOHN J. BROWN</p>		<p>AGE 45</p>		<p>SEX Male</p>		<p>RACE White</p>		<p>DATE OF BIRTH Jan 15, 1880</p>		<p>PLACE OF BIRTH Baltimore, Md.</p>	
<p>RESIDENCE 1234 Main St., Baltimore, Md.</p>		<p>DATE OF DEATH Dec 10, 1925</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>CAUSE OF DEATH Heart Disease</p>		<p>PLACE OF DEATH Home</p>		<p>DATE OF INTERMENT Dec 12, 1925</p>	
<p>NAME OF PHYSICIAN Dr. J. H. Smith</p>		<p>NAME OF FUNERAL HOME Brown & Sons</p>		<p>NAME OF BURIAL PLACE Greenwood Cemetery</p>		<p>NAME OF MINISTER Rev. W. D. Jones</p>		<p>NAME OF WITNESS John J. Brown</p>		<p>NAME OF WITNESS Mary J. Brown</p>	
<p>NAME OF WITNESS John J. Brown</p>		<p>NAME OF WITNESS Mary J. Brown</p>		<p>NAME OF WITNESS John J. Brown</p>		<p>NAME OF WITNESS Mary J. Brown</p>		<p>NAME OF WITNESS John J. Brown</p>		<p>NAME OF WITNESS Mary J. Brown</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02002

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b Several hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Armory				d. STREET ADDRESS 10,106 Georgia Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Platt Bull Sr.				4. DATE OF DEATH Month Feb. Day 22 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1890		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY Garfinkel's Dept. Store		11. BIRTHPLACE (State or foreign country) Newburg, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Platt Bull				14. MOTHER'S MAIDEN NAME Carrie Toleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 168-26-7391 063-12-6521		17. INFORMANT Address Mrs. Ella F. Bull, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				DATE SIGNED 2/22/59			
EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Feb. 24, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince George's County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wagner E. Pumphrey, Inc. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2031

CERTIFICATE OF DEATH

Reg. Dist. No.

02003

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 20 min NB d. NAME OF HOSPITAL (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE 26 d. STREET ADDRESS 1 AVERY ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DAVID LESTER BUTT			4. DATE OF DEATH Month Day Year FEBRUARY 14 19 59				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/59		9. AGE (In years last birthday) yrs. 20		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME PRESTON EUGENE BUTT			14. MOTHER'S MAIDEN NAME CATHERINE PAULINE CROWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS Address OLNEY, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion of cerebrum 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from FEB. 14 , 19 59 , to FEB. 14 , 19 59 , that I last saw the deceased alive on FEB. 14 , 19 59 , and that death occurred at 3:05 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/14/59							
ACTUAL SIGNATURE A.D. Bonifant		M.D. A.D. BONIFANT, M.D.					
PHYSICIAN'S NAME (Type)		SANDY SPRING, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/59	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 25 '59		
			24b. REGISTRAR'S SIGNATURE Arthur S. Hines				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073295XV2

1 2032 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02004

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83 x. 3 d. STREET ADDRESS 1130 S. 16th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Berton Johnson BYERS			4. DATE OF DEATH Month February Day 4 Year 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-10		9. AGE (In years last birthday) 48 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Tennessee			
13. FATHER'S NAME Charles Clinton BYERS			14. MOTHER'S MAIDEN NAME Mary Frances HUTCHINSON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) 1927 to 1959		16. SOCIAL SECURITY NO. 420-52-5087		17. INFORMANT Address (W) Agnes Marie Byers, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Infection of Myocardium DUE TO (b) arteriosclerotic heart Disease DUE TO (c) 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from February 3, 1959 , to February 4, 1959 , that I last saw the deceased alive on February 4, 1959 , and that death occurred at 11:03 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. G. Muth		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 2-5-59			
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
				22d. LOCATION (City, town, or county) (State) Arlington Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave. NW, Washington			24a. REC'D BY REGISTRAR DATE FEB 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2033

CERTIFICATE OF DEATH

Reg. Dist. No.

02005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>J.</u> Last <u>Caldwell</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15, 1881</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES H. JACKSON</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ANN POLING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT Address <u>Mrs. Sidney A. Peters - 7 Hawth # 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Branchiectasis, bilateral, Chronic Sv.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u>		Month <u></u> Day <u>19</u> Year <u>1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>			
21. I certify that I attended the deceased from <u>Feb 4</u> , 19 <u>59</u> , to <u>Feb 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>59</u> , and that death occurred at <u>6 A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl H Mitchell</u>				ADDRESS (Street, city or town, state) <u>2029 Q St N.W., Wash. D.C.</u>			
DATE SIGNED <u>Feb 8, 59</u>							
PHYSICIAN'S NAME (Type) <u>Earl H. Mitchell</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. - Transit</u>				22d. LOCATION (City, town, or county) (State) <u>St. Petersburg, Florida</u>			
22b. DATE THEREOF <u>2/10/59</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 '59</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Rungling</u>				24b. REGISTRAR'S SIGNATURE <u>Robert D. Rungling</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2034

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edgar Edwin CALDWELL			4. DATE OF DEATH Month Day Year February 23 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-92		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Caldwell				14. MOTHER'S MAIDEN NAME Laura Adele Whitney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & WWII 212-28-1620		17. INFORMANT Address (W) Mary Agnes Caldwell, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4-6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 6, 1959 , to February 23, 1959 , that I last saw the deceased alive on February 21, 1959 , and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Horgan				ADDRESS (Street, city or town, state) U. S. Naval Hospital		DATE SIGNED 2-24-59	
PHYSICIAN'S NAME (Type) J. T. HORGAN LCDR MC USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORY Annapolis National		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons, Annapolis, Md.				24a. REC'D BY REGISTRAR DATE FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM BOYD

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Death	
County		City	
State		Country	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10112 Pierce Dr</u>			1. STREET ADDRESS <u>10112 Pierce Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Altha</u> Middle <u>Pearl</u> Last <u>Campbell</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-1891</u>		9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
13. FATHER'S NAME <u>Wm A Easterday</u>			14. MOTHER'S MAIDEN NAME <u>Annie Pearson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John J. Campbell</u> Address <u>Itm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease for several years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
22d. LOCATION (City, town, or county)		(State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

FOR STATE
HEALTH OFFICE

MARYLAND STATE BOARD OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2088

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Uremia 2036 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				d. STREET ADDRESS 3703 Thornapple Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Gordon First G. Middle Canaga Last				4. DATE OF DEATH Feb. 26 1959		Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1887		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT Mary L. Canaga-wife-same as 2d Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia, terminal DUE TO (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis generalized DUE TO								INTERVAL BETWEEN ONSET AND DEATH One month 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, right, severe, 2 mos.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , to Feb. 26, 1959 , that I lost saw the deceased olive on Feb. 25, 1959 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Stewart Clapp M.D.						ADDRESS (Street, city or town, state) 3921 Ingomar St NW D.C. DATE SIGNED 2-26-59			
PHYSICIAN'S NAME (Type) Stewart Clapp						Wash D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>Jan 15 1912</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>CITY OF RESIDENCE <i>Baltimore</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PREVIOUS DISEASES <i>Hypertension</i></p>		<p>DATE OF INTERMENT <i>Jan 17 1912</i></p>	
<p>PLACE OF INTERMENT <i>St. Mary's Cemetery</i></p>		<p>NAME OF MINISTER <i>Rev. J. H. Smith</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>J. H. Smith</i></p>		<p>SIGNATURE OF CLERK <i>J. H. Smith</i></p>	
<p>DATE OF SIGNATURE <i>Jan 15 1912</i></p>		<p>DATE OF SIGNATURE <i>Jan 15 1912</i></p>	

2037

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DASPER LEE CANFIELD				4. DATE OF DEATH Month Day Year FEBRUARY 25 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/70	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME Unk own				14. MOTHER'S MAIDEN NAME Unk own			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no				16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS Address OLNEY, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, Arteriosclerotic DUE TO (c) Gangrene.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1955 , 19 55 , to 2/25 , 19 59 , that I last saw the deceased alive on 2/25 , 19 59 , and that death occurred at 2:40P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. I. Leal				ADDRESS (Street, city or town, state) South Channing road. DATE SIGNED			
PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.				GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2-28-59		Hiney Cemetery		Linn, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR MAR 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		COUNTY BALTIMORE	
NAME OF DECEASED JAMES EARL RAY		SEX MALE	
DATE OF DEATH APRIL 4, 1968		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH MOBILE, ALABAMA		AGE 35	
OCCUPATION MEMBER OF CONGRESS		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF REGISTRAR [Signature]	

RECEIVED
 BALTIMORE, MD
 APRIL 10, 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2038 CERTIFICATE OF DEATH

02010

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>56 days</u>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>1406 Allison Street N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Francis CARMODY</u>				4. DATE OF DEATH <u>February 7 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3-19-76</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Timothy CARMODY</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Ann ALIMAN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 1892 to 1926</u>			
16. SOCIAL SECURITY NO. <u>1892 to 1926</u>				17. INFORMANT <u>Mary C. CARMODY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 12, 1958</u> to <u>February 7, 1959</u> , that I last saw the deceased alive on <u>February 7, 1959</u> , and that death occurred at <u>1:14 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Wood Davis</u> M.D. <u>U.S. Naval Hospital NVMC,</u>				ADDRESS (Street, city or town, state) <u>Bethesda, 14 Maryland</u>			
PHYSICIAN'S NAME (Type) <u>J.W. DAVIS LT MC USN</u>				DATE SIGNED <u>2-8-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
22d. LOCATION (City, town, or county) <u>Arlington</u>		(State) <u>VA.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. HINES</u>		ADDRESS <u>2901 14th Street N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		24c. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

838

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		PLACE OF BURIAL _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CLERK _____		SIGNATURE OF WITNESS _____	
CITY _____		COUNTY _____		STATE _____	
YEAR _____		MONTH _____		DAY _____	
HOUR _____		MINUTE _____		SECOND _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF CLERK _____		SIGNATURE OF WITNESS _____	
CITY _____		COUNTY _____		STATE _____	
YEAR _____		MONTH _____		DAY _____	
HOUR _____		MINUTE _____		SECOND _____	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

2039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b - - - - -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3522 Raymond Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MODENIA Middle M. Last CHESTER				4. DATE OF DEATH Month Feb. Day 20 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1865	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 10 Days 11	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph I. Dunn				14. MOTHER'S MAIDEN NAME Mildred Craig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Address Clay G. Walker - as above #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Coronary Arteriosclerosis - Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Sclerosis DUE TO (c) Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1959 to Feb. 20, 1959 that I last saw the deceased alive on July 19, 1959 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Chester Brady		M.D.		ADDRESS (Street, city or town, state) 3522 Raymond Street, Chevy Chase, Md.		DATE SIGNED Feb. 20, 1959	
PHYSICIAN'S NAME (Type) J. Chester Brady, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans.		22b. DATE THEREOF 2-23-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.		22d. LOCATION (City, town, or county) (State) Calloway Co., Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.				24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8032

STATE OF CALIFORNIA

Montgomery

Montgomery

Heavy Chase

Heavy Chase

1232 Bayview Street

1232 Bayview Street

MONTANA

April 20, 1932

White

White

Housewife

Housewife

Joseph L. Brown

Joseph L. Brown

No

1000

Heavy Chase

Montgomery

Montgomery

Montgomery

Robert A. Humphrey, Bethesda 14, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2040

CERTIFICATE OF DEATH

00750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				d. STREET ADDRESS <u>1711 Orchard Way</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Ellen</u> Last <u>CLARKE</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 3 - 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>Eli Ball Stokes</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Bessie Stokes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Ms. E. L. Borch</u>				Address <u>711 Orchard Pl. S.S. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy, thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 Mos.</u> <u>10445</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u>a. j.</u> Month <u> </u> Day <u> </u> Year <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 29</u> , 19 <u>59</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. D. Bonifant</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>				DATE SIGNED <u>2/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (specify) <u>burial</u>		22b. DATE THEREOF <u>2/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. D. A. Nixon</u>				ADDRESS <u>2801-18th St. N.W. Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. DATE OF DEATH [Illegible]</p>	
<p>9. TIME OF DEATH [Illegible]</p>		<p>10. PLACE OF DEATH [Illegible]</p>	
<p>11. CAUSE OF DEATH [Illegible]</p>		<p>12. MEDICAL HISTORY [Illegible]</p>	
<p>13. HISTORY OF PRESENT ILLNESS [Illegible]</p>		<p>14. PHYSICIAN'S SIGNATURE [Illegible Signature]</p>	
<p>15. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>16. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>17. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>18. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>19. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>20. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>21. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>22. SIGNATURE OF WITNESS [Illegible Signature]</p>	
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<p>81. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>82. SIGNATURE OF WITNESS [Illegible Signature]</p>	
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<p>89. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>90. SIGNATURE OF WITNESS [Illegible Signature]</p>	
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<p>95. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>96. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>97. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>98. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>99. SIGNATURE OF DECEASED [Illegible Signature]</p>		<p>100. SIGNATURE OF WITNESS [Illegible Signature]</p>	

STATE OF MASSACHUSETTS
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL RECORDS
 100 STATE STREET, BOSTON, MASS.
 02109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2041

CERTIFICATE OF DEATH

Reg. Dist. No.

02012

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY <u>Atlantic</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic City N.J.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				d. STREET ADDRESS <u>140 So. Rhode Island St.</u>			
3. NAME OF DECEASED (Type or print) <u>Cecelia</u> First <u>Cohen</u> Middle <u>Cohen</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-1894</u>	9. AGE (In years lost birth day) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>	
13. FATHER'S NAME <u>Simoon Pickner</u>				14. MOTHER'S M maiden name <u>Unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Carl Golden 3208 Saline St. Chevy Chase, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Gallbladder with metastases</u> 155.1 DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 11, 1959</u> , to <u>Feb 26, 1959</u> , that I last saw the deceased alive on <u>Feb 25, 1959</u> , and that death occurred at <u>12:5</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabkin M.D.</u>				ADDRESS (Street, city or town, state) <u>1019 University Boulevard Silver Spring, Maryland</u>		DATE SIGNED <u>Feb 26, 1959</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Shalom Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield Twp. Del Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey Inc.</u>				ADDRESS <u>8434 Georgia St.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02013

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 75x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 1249 N. 2nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Forest COLLINS II				4. DATE OF DEATH Month Day Year February 26 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-39		9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel COLLINS				14. MOTHER'S MAIDEN NAME Margaret STARR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1956 to DOD 180-30-8304		17. INFORMANT Address (M) Mrs. Margaret S. Collins, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 822x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in jeep which hit rut and overturned					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9:30 xx 2-20 1959	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Marine Corps Base, Quantico, Va.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-27-59	
EXAMINER'S NAME (Type) Frank J. BROSCART, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-2-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest A. Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC				24a. REC'D BY REGISTRAR MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2043
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1826 New Hampshire Ave., N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Douglass COLLINS				4. DATE OF DEATH Month Day Year February 27 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-93		9. AGE (In years last birthday) yrs. 65	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Policeman			10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.			11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Jeremiah COLLINS			14. MOTHER'S MAIDEN NAME Mary (Unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI 577-20-8757		17. INFORMANT Address (W) Mrs. Amanda H. Collins, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330x Subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive vascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 20 hrs. 15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from February 26, 1959 , to February 27, 1959 , that I last saw the deceased alive on February 27, 1959 , and that death occurred at 1:15 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Muth				M.D. U. S. Naval Hospital, NNMC		DATE SIGNED 2-27-59	
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Rufus N. Horton Co., 1322 U STREET, NW, Wash, DC				24a. REC'D BY REGISTRAR DATE MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

4094 JGIM

2044
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>14422-BROOKFIELD DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>B.</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 23, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT E. WEAVER</u>		14. MOTHER'S MAIDEN NAME <u>THERESA HALLINAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHN COLLINS</u>		Address <u>7805 GREENWOOD AVE TAKOMA PARK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>6 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Angina Pectoris</u> <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>59</u> , to <u>Feb. 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 3</u> , 19 <u>59</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifton R. Gruver</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4325 49th St. N.W.</u> <u>2/7/59</u>	
PHYSICIAN'S NAME (Type) <u>CLIFTON R. GRUVER</u>		<u>4325 49th St. N.W.</u> <u>2/7/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-10-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulen</u>		ADDRESS <u>3531 In Ave N.W.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1875		5. PLACE OF BIRTH Manitowoc, Wis.	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH 1940		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF WITNESSES J. H. Harris		18. SIGNATURE OF FUNERAL HOME J. H. Harris		19. SIGNATURE OF BURIAL PLACE J. H. Harris		20. SIGNATURE OF INTERVIEWER J. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02016

2045

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8800 Ridge Road				d. STREET ADDRESS 8800 Ridge Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Otto Middle Connell Last Cott				4. DATE OF DEATH Month 2 Day 10 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/26/1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min. 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Government Employee		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. Government Employee				13. FATHER'S NAME John Wm. Cott			
14. MOTHER'S MAIDEN NAME Mary Victoria Johnson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Nora W. Cott-8800 Ridge Rd. Bethesda, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardio vascular renal disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden 6 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 35 , to Feb 10 , 19 59 , that I last saw the deceased alive on Feb 7 , 19 59 , and that death occurred at 6:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1832 Baltimore St N W Washington D.C. DATE SIGNED Feb 10 1959							
ACTUAL SIGNATURE E.E. Quayle M.D.				PHYSICIAN'S NAME (Type) E.E. Quayle, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/13/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery Arlington, Virginia	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company ADDRESS Washington, D.C.				24a. REC'D BY REGISTRAR FEB 16 '59 DATE Feb 16 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1900		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH Dec 10, 1945		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF NEXT OF KIN [Signature]		20. SIGNATURE OF CLERK [Signature]	

02017

2046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PETER B CROSS</u>				4. DATE OF DEATH Month Day Year <u>FEB 4 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 3, 1959</u>	9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>THOMAS B CROSS JR.</u>				14. MOTHER'S MAIDEN NAME <u>JEAN BERNARDI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>THOMAS B CROSS</u>		Address <u>FATHER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congestive Heart failure</u> DUE TO <u>CONGENITAL HEART DISEASE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 4, 1959</u> , 19 <u>59</u> , to <u>FEB 4, 1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEB 4, 1959</u> , 19 <u>59</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Frederic Gerard Burke</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>FREDERIC GERARD BURKE - 3118 16TH ST. N.W. - D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter 3603 14th St NW</u> ADDRESS <u>WASHINGTON</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074251XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1989

CERTIFICATE OF DEATH

Reg. Dist. No.

02018

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>1641.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Lawson Crothers 111</u>		4. DATE OF DEATH First Middle Last <u>2</u> <u>28</u> <u>1959</u>		Month <u>2</u> Day <u>28</u> Year <u>1959</u>		5. SEX <u>male</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2/27/59</u>		9. AGE (In years last birthday) yrs. <u>13</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>John Lawson Crothers Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Betty Irene Browne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>father</u>		17. INFORMANT <u>father</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS, RESORPTION TYPE.</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYALINE MEMBRANE DIS.</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>24 H.</u> <u>life</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While on work <input type="checkbox"/> Not while on work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/27/59</u> , 1959, to <u>2/28/59</u> , 1959, that I last saw the deceased alive on <u>2/28/59</u> , 1959, and that death occurred at <u>9:35</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 7309 Riggs Rd., Hyattsville, Maryland</u> DATE SIGNED <u>31/59</u>							
ACTUAL SIGNATURE <u>Joseph J. McDonald</u>		PHYSICIAN'S NAME (Type) <u>Joseph J. McDonald, M. D. 7309 Riggs Road, Hyattsville, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Cliffs, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Shant North East Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

1000282XV5

CERTIFICATE OF DEATH

File No. 100

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CITY

DATE OF DEATH

PLACE OF DEATH

CITY

CAUSE OF DEATH

PLACE OF DEATH

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NOT VALID WITHOUT SIGNATURE OF DECEASED OR HIS NEXT OF KIN
 DATE OF BIRTH
 PLACE OF BIRTH
 CITY
 STATE
 COUNTY
 ZIP CODE
 TO BE FILLED BY DECEASED OR HIS NEXT OF KIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,3 FilmG239 3-16-59 et

2047

CERTIFICATE OF DEATH

Reg. Dist. No.

02019

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #3		d. STREET ADDRESS Route B # 1, Box 203	
3. NAME OF DECEASED (Type or print) First William Middle Veirs Last Dawson		4. DATE OF DEATH Month February Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 7 Days 27	11. IF UNDER 24 HRS. Hours 27 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Dawson		14. MOTHER'S MAIDEN NAME Emma Veirs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-9562	
17. INFORMANT Virginia M. Dawson-wife-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ventricular Tachycardia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11 , 19 56 , to Feb. 26 , 19 59 that I last saw the deceased alive on Feb 25 , 19 59 , and that death occurred at 8:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen C. Cromwell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 615 W. Montgomery Ave 2/26/59 Rockville, Md	
PHYSICIAN'S NAME (Type) Stephen C. Cromwell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/59	22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery	22d. LOCATION (City, town, or county) (State) Beallsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 3 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN SENATE

January 12, 2004

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

RELATIVE TO THE LANDS BELONGING TO THE STATE OF TEXAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2048

CERTIFICATE OF DEATH

Reg.-Dist. No.

02020

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.				c. LENGTH OF STAY IN 1b 15 days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General				d. STREET ADDRESS 821 Snider Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Anderson Deitz				4. DATE OF DEATH Month 2 Day 8 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-28-89 69		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Postal Transp. Personnel retired U. S. Gov't.				11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert A. Deitz				14. MOTHER'S MAIDEN NAME Mary Stull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Medical Records, Olney, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 587.0 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Pancreatitis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 14 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 1/25 , 19 59 , to 2/8 , 19 59 , that I last saw the deceased alive on 2/8 , 19 59 , and that death occurred at 7:27 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE C. H. Ligon, M.D.				M.D. _____			
PHYSICIAN'S NAME (Type) C. H. Ligon, M.D.				Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/11/59		22c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY		22d. LOCATION (City, town, or county) _____ (State) _____ STRASBURG, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond J. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kross			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

REPORTED BY

DATE OF REPORT

DECEASED'S NAME

DECEASED'S ADDRESS

DECEASED'S OCCUPATION

DECEASED'S AGE

DECEASED'S SEX

DECEASED'S RACE

DECEASED'S MARITAL STATUS

DECEASED'S EDUCATION

DECEASED'S RELIGION

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S BIRTH RECORD NUMBER

DECEASED'S BIRTH DATE (REPEATED)

DECEASED'S BIRTH PLACE (REPEATED)

DECEASED'S BIRTH RECORD NUMBER (REPEATED)

DECEASED'S BIRTH DATE (REPEATED)

DECEASED'S BIRTH PLACE (REPEATED)

DECEASED'S BIRTH RECORD NUMBER (REPEATED)

DECEASED'S BIRTH DATE (REPEATED)

DECEASED'S BIRTH PLACE (REPEATED)

DECEASED'S BIRTH RECORD NUMBER (REPEATED)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02021

2049

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1611 Moffett Rd 56</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Le Dear Gynecology Nursing Home</u>				d. STREET ADDRESS <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIE</u> First <u>Doretta</u> Middle <u>Dern</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 3 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Broschert</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Char. J. Dern</u>		Address <u>Steen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of rt hip about 3 mo. ago.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 25 '59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>R.F.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mertie Berena Ditzler</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-75</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James G. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Lucina Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Lyle H. Ditzler, Rt 1 Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchopneumonia, bilateral</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Infarction floor fourth ventricle of brain</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>59</u> , to <u>Feb 7</u> , 19 <u>59</u> , that I lost saw the deceased olive on <u>Feb 7</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u>				ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave</u> DATE SIGNED <u>2/8/59</u>			
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>				<u>Rockville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>2/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Whittier, California</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02023

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2910 Blue Ridge Ave</u>				d. STREET ADDRESS <u>12910 Blue Ridge Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Agnes Louise Dodson</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1901</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of Agri.</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MICHAEL J. Wevill</u>				14. MOTHER'S MAIDEN NAME <u>Esther Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Roy E. Dodson -</u>		Address <u>Stun</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-28-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00751

2052

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>13415 Wake Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Jeanine</u> First <u>Carole</u> Middle <u>Duvall</u> Last			4. DATE OF DEATH <u>February 2</u> 1959 Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23, 1958</u>		9. AGE (In years last birthday) <u>1</u> yrs. <u>10</u> Months <u>10</u> Days <u></u> Hours <u></u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Bernard Edward Duvall</u>			14. MOTHER'S MAIDEN NAME <u>Grace Beverly Simmonds</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Bernard Duvall (father)</u> Address <u>3415 Wake Dr Kensington, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Upper Respiratory Infection</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Found collapsed in bed</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Blossch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-2-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BLOSSCH</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>			ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u>
			24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kraus</u>		

21074347XV4

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____
2. Date of Death: _____
3. Place of Death: _____
4. Age: _____
5. Sex: _____
6. Race: _____
7. Occupation: _____
8. Cause of Death: _____
9. Manner of Death: _____
10. Signature of Medical Examiner: _____
11. Date of Examination: _____
12. Signature of Coroner: _____
13. Date of Filing: _____
14. Signature of Registrar: _____
15. Date of Registration: _____

RECEIVED
BALTIMORE, MD.
JAN 10 1910

2053

CERTIFICATE OF DEATH

Reg. Dist. No.

02024

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2/14/59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		d. STREET ADDRESS 732 THAYER AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LE DEAU GARDENS NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES EDWARD FAULCONER				4. DATE OF DEATH Month Day Year FEB. 23 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS REP., SHEET METAL WORKERS UNION		10b. KIND OF BUSINESS OR INDUSTRY CULPEPPER, VA.		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN B. FAULCONER				14. MOTHER'S MAIDEN NAME MARY UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-01-4807		17. INFORMANT Address MD. MRS. ROBERT J. LEARY, 3830 WENDY LANE, SILVER SPRING,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 11 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 1956 , to Feb 23, 1959 , that I last saw the deceased alive on Feb 19, 1959 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring Md DATE SIGNED Feb 23 '59 ACTUAL SIGNATURE Aaron H. Traum M.D. PHYSICIAN'S NAME (Type) AARON H. TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEMETERY RIGGS RD. PR. GEO. CO. MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2054

CERTIFICATE OF DEATH

Reg. Dist. No.

02025

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 132 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 6407 Winnepeg Road			
3. NAME OF DECEASED (Type or print) First Kathleen Middle Marie Last Finotti				4. DATE OF DEATH Month February Day 8 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1952	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Finotti				14. MOTHER'S MAIDEN NAME Marie Lanahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grown Negative Septicaemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphocytic Leukemia DUE TO (c) months INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from September 29 1958 , to February 8 1959 , that I last saw the deceased alive on February 8 1959 , and that death occurred at 2:20a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2/8/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Nathan S. Taylor M.D.				PHYSICIAN'S NAME (Type) NATHAN S. TAYLOR, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2/10/59		Gate of Heaven		Mount Airy	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Humphreys & Son				ADDRESS 5132		24a. REC'D BY REGISTRAR DATE FEB 10 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hous							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2055

CERTIFICATE OF DEATH

02026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2010 Avalon Place,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marguerite Mary Fitzpatrick</u>				4. DATE OF DEATH Month Day Year <u>February 6, 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lawrence A. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Margaret May</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>James J. Fitzpatrick, 2010 Avalon P 1.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> (c) <u>2-3 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>February 6, 19 59</u> that I last saw the deceased alive on <u>February 6, 19 59</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert B. Ireys</u> M.D. <u>7105 Riggs Road, Hyattsville, Md.</u> <u>2/6/59</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Robert B. Ireys</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>				ADDRESS <u>2224 Wis. Ave. N.W. - D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1990

CERTIFICATE OF DEATH

Reg. Dist. No.

12027

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>—</u> b. COUNTY <u>—</u> 476-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15koma Park</u>		c. LENGTH OF STAY IN 1b <u>48 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C. - N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>2400 19th St. Apt. 104</u>			
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Martha</u> Last <u>Fodor</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-99</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Emil Roob</u>			14. MOTHER'S MAIDEN NAME <u>Maria Huszar</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac - Respiratory failure</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- malnutrition and sec. anemia</u> DUE TO (c) <u>- Cancer of the bowel 2 miles from the liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 23rd</u> , 1958, to <u>Feb. 10</u> , 1959, that I last saw the deceased alive on <u>Feb. 9</u> , 1959, and that death occurred at <u>2:40</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10236 N.H. Ave. Silver Spring Maryland</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Veronica Troost</u>			M.D. <u>10236 N.H. Ave. Silver Spring Maryland</u>				
PHYSICIAN'S NAME (Type) <u>VERONICA TROOST</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Feb. 12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olaf</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md. N.H. Ave.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>				ADDRESS <u>254 Carroll St. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 days & 5 hrs. Silver Spring 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 152 C Colony Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle ANGELA Last FOY				4. DATE OF DEATH Month Feb. Day 19 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1959	
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 0 Days 2 Hours 5 Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William J. Foy				14. MOTHER'S MAIDEN NAME Elizabeth Mess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT William J. Foy, 152 C. Colony Rd., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURE 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from FEB 17, 1959 , to FEB 19, 1959 , that I last saw the deceased alive on FEB 19, 1959 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1515 HIGHLAND DRIVE SILVER SPRING, MD. DATE SIGNED George R. Spence							
ACTUAL SIGNATURE George R. Spence M.D. 1515 HIGHLAND DRIVE SILVER SPRING, MD.							
PHYSICIAN'S NAME (Type) GEORGE R. SPENCE M.D., SILVER SPRING, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/59		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md. Raymond W. Ziska				24a. REC'D BY REGISTRAR DATE FEB 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074261XVV

CERTIFICATE OF DEATH

2025

NAME OF DECEASED [Name]		SEX [Male/Female]		RACE [Race]	
DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]		MARRIAGE [Status]	
DATE OF DEATH [Date]		PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]		MEDICAL HISTORY [History]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]		SIGNATURE OF WITNESS [Signature]	
NAME OF PHYSICIAN [Name]		NAME OF CORONER [Name]		NAME OF WITNESS [Name]	
ADDRESS OF PHYSICIAN [Address]		ADDRESS OF CORONER [Address]		ADDRESS OF WITNESS [Address]	
CITY OF PHYSICIAN [City]		CITY OF CORONER [City]		CITY OF WITNESS [City]	
STATE OF PHYSICIAN [State]		STATE OF CORONER [State]		STATE OF WITNESS [State]	
COUNTY OF PHYSICIAN [County]		COUNTY OF CORONER [County]		COUNTY OF WITNESS [County]	
ZIP CODE OF PHYSICIAN [ZIP]		ZIP CODE OF CORONER [ZIP]		ZIP CODE OF WITNESS [ZIP]	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed with the local health department and a copy sent to the State Department of Health.

The information furnished on this certificate is for statistical purposes only and is not to be used for legal purposes.

The undersigned hereby certifies that the information furnished on this certificate is true and correct to the best of his knowledge and belief.

[Signature]

[Name]

[Title]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2057

CERTIFICATE OF DEATH

Reg. Dist. No.

02029

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4914 - Greenway Drive</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shenandoah Md.</u>	
c. LENGTH OF STAY IN 1b <u>1 year</u>		d. STREET ADDRESS <u>4914 - Greenway Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie amy Freet</u>		4. DATE OF DEATH Month Day Year <u>Feb. 22 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20, 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>H. S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Wesley Steas</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-26-4880A</u>	
17. INFORMANT <u>Mrs. Ruth Joseph Greenway</u>		Address <u>4914 -</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE GASTROINTESTINAL HEMORRHAGE</u> <u>583X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HEPATIC COMA (RUPTURED VARICES (ESOPHAGEAL))</u> cause (c) <u>CHRONIC LIVER DISEASE</u> lying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>NONE 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>58</u> , to <u>FEBRUARY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEBRUARY 21</u> , 19 <u>59</u> , and that death occurred at <u>1:40 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Edward S. Witowski Jr.</u> M.D. <u>SUITE 400, 8318 WISCONSIN AVE.</u> <u>2/22/59</u> PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI, JR. M.D.</u> <u>BETHESDA 14 MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Shenandoah Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adams Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '59</u>	
ADDRESS <u>4748 - Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 11, 12 Film G238 2-13-59 et
1991
CERTIFICATE OF DEATH

02030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sherrie Lynn Friedlander</u>				4. DATE OF DEATH Month Day Year <u>Feb. 6 1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26-58</u>		9. AGE (In years lost birthday) yrs. <u>3</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Mr. Jerome Friedlander</u>				14. MOTHER'S MAIDEN NAME <u>DORIS OSHINSKY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL CARDIAC SEPTAL DEFECT</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POSSIBLE CEREBRAL PALSY (2) POSSIBLE MICROCEPHALY</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>SINCE BIRTH</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 3, 1959</u> , to <u>Feb. 6, 1959</u> , that I last saw the deceased alive on <u>Feb 5, 1959</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stanley Gould</u>				ADDRESS (Street, city or town, state) <u>3222 DAVENPORT ST. N.W. WASHINGTON, D.C.</u>		DATE SIGNED <u>2/6/59</u>	
PHYSICIAN'S NAME (Type) <u>STANLEY GOULD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oxon Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u> ADDRESS <u>3445-3401-14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruus</u>	

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1

CERTIFICATE OF DEATH

1931

See Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. COUNTY		18. DISTRICT		19. CITY		20. STATE		21. ZIP CODE		22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF BURIAL OFFICIAL	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF BURIAL OFFICIAL		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF REGISTRAR		30. SIGNATURE OF WITNESSES		31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF BURIAL OFFICIAL		36. SIGNATURE OF PHYSICIAN		37. SIGNATURE OF REGISTRAR		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF DECEASED		40. SIGNATURE OF NEXT OF KIN	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF BURIAL OFFICIAL		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR		46. SIGNATURE OF WITNESSES		47. SIGNATURE OF DECEASED		48. SIGNATURE OF NEXT OF KIN	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF BURIAL OFFICIAL		52. SIGNATURE OF PHYSICIAN		53. SIGNATURE OF REGISTRAR		54. SIGNATURE OF WITNESSES		55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF BURIAL OFFICIAL		60. SIGNATURE OF PHYSICIAN		61. SIGNATURE OF REGISTRAR		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF DECEASED		64. SIGNATURE OF NEXT OF KIN	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF BURIAL OFFICIAL		68. SIGNATURE OF PHYSICIAN		69. SIGNATURE OF REGISTRAR		70. SIGNATURE OF WITNESSES		71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF BURIAL OFFICIAL		76. SIGNATURE OF PHYSICIAN		77. SIGNATURE OF REGISTRAR		78. SIGNATURE OF WITNESSES		79. SIGNATURE OF DECEASED		80. SIGNATURE OF NEXT OF KIN	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF BURIAL OFFICIAL		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF DECEASED		88. SIGNATURE OF NEXT OF KIN	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF BURIAL OFFICIAL		92. SIGNATURE OF PHYSICIAN		93. SIGNATURE OF REGISTRAR		94. SIGNATURE OF WITNESSES		95. SIGNATURE OF DECEASED		96. SIGNATURE OF NEXT OF KIN	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF BURIAL OFFICIAL		100. SIGNATURE OF PHYSICIAN		101. SIGNATURE OF REGISTRAR		102. SIGNATURE OF WITNESSES		103. SIGNATURE OF DECEASED		104. SIGNATURE OF NEXT OF KIN	
105. SIGNATURE OF DECEASED		106. SIGNATURE OF NEXT OF KIN		107. SIGNATURE OF BURIAL OFFICIAL		108. SIGNATURE OF PHYSICIAN		109. SIGNATURE OF REGISTRAR		110. SIGNATURE OF WITNESSES		111. SIGNATURE OF DECEASED		112. SIGNATURE OF NEXT OF KIN	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF NEXT OF KIN		115. SIGNATURE OF BURIAL OFFICIAL		116. SIGNATURE OF PHYSICIAN		117. SIGNATURE OF REGISTRAR		118. SIGNATURE OF WITNESSES		119. SIGNATURE OF DECEASED		120. SIGNATURE OF NEXT OF KIN	
121. SIGNATURE OF DECEASED		122. SIGNATURE OF NEXT OF KIN		123. SIGNATURE OF BURIAL OFFICIAL		124. SIGNATURE OF PHYSICIAN		125. SIGNATURE OF REGISTRAR		126. SIGNATURE OF WITNESSES		127. SIGNATURE OF DECEASED		128. SIGNATURE OF NEXT OF KIN	
129. SIGNATURE OF DECEASED		130. SIGNATURE OF NEXT OF KIN		131. SIGNATURE OF BURIAL OFFICIAL		132. SIGNATURE OF PHYSICIAN		133. SIGNATURE OF REGISTRAR		134. SIGNATURE OF WITNESSES		135. SIGNATURE OF DECEASED		136. SIGNATURE OF NEXT OF KIN	
137. SIGNATURE OF DECEASED		138. SIGNATURE OF NEXT OF KIN		139. SIGNATURE OF BURIAL OFFICIAL		140. SIGNATURE OF PHYSICIAN		141. SIGNATURE OF REGISTRAR		142. SIGNATURE OF WITNESSES		143. SIGNATURE OF DECEASED		144. SIGNATURE OF NEXT OF KIN	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF BURIAL OFFICIAL		148. SIGNATURE OF PHYSICIAN		149. SIGNATURE OF REGISTRAR		150. SIGNATURE OF WITNESSES		151. SIGNATURE OF DECEASED		152. SIGNATURE OF NEXT OF KIN	
153. SIGNATURE OF DECEASED		154. SIGNATURE OF NEXT OF KIN		155. SIGNATURE OF BURIAL OFFICIAL		156. SIGNATURE OF PHYSICIAN		157. SIGNATURE OF REGISTRAR		158. SIGNATURE OF WITNESSES		159. SIGNATURE OF DECEASED		160. SIGNATURE OF NEXT OF KIN	
161. SIGNATURE OF DECEASED		162. SIGNATURE OF NEXT OF KIN		163. SIGNATURE OF BURIAL OFFICIAL		164. SIGNATURE OF PHYSICIAN		165. SIGNATURE OF REGISTRAR		166. SIGNATURE OF WITNESSES		167. SIGNATURE OF DECEASED		168. SIGNATURE OF NEXT OF KIN	
169. SIGNATURE OF DECEASED		170. SIGNATURE OF NEXT OF KIN		171. SIGNATURE OF BURIAL OFFICIAL		172. SIGNATURE OF PHYSICIAN		173. SIGNATURE OF REGISTRAR		174. SIGNATURE OF WITNESSES		175. SIGNATURE OF DECEASED		176. SIGNATURE OF NEXT OF KIN	
177. SIGNATURE OF DECEASED		178. SIGNATURE OF NEXT OF KIN		179. SIGNATURE OF BURIAL OFFICIAL		180. SIGNATURE OF PHYSICIAN		181. SIGNATURE OF REGISTRAR		182. SIGNATURE OF WITNESSES		183. SIGNATURE OF DECEASED		184. SIGNATURE OF NEXT OF KIN	
185. SIGNATURE OF DECEASED		186. SIGNATURE OF NEXT OF KIN		187. SIGNATURE OF BURIAL OFFICIAL		188. SIGNATURE OF PHYSICIAN		189. SIGNATURE OF REGISTRAR		190. SIGNATURE OF WITNESSES		191. SIGNATURE OF DECEASED		192. SIGNATURE OF NEXT OF KIN	
193. SIGNATURE OF DECEASED		194. SIGNATURE OF NEXT OF KIN		195. SIGNATURE OF BURIAL OFFICIAL		196. SIGNATURE OF PHYSICIAN		197. SIGNATURE OF REGISTRAR		198. SIGNATURE OF WITNESSES		199. SIGNATURE OF DECEASED		200. SIGNATURE OF NEXT OF KIN	

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, DO HEREBY CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD OF DEATH AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR THE YEAR 1931.

2058

CERTIFICATE OF DEATH

Reg. Dist. No.

02031

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 2½ Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Pauline Boyd's Nursing 1800 Grace Church Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAUL S. GABLE				4. DATE OF DEATH FEB. 7 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-70	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Referee				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Printg. Of.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Jacob Benton Gable				14. MOTHER'S MAIDEN NAME Caroline A. Staley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Paul DeLong Gable, 1908 Hanover St, S.S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Cardio Vascular Renal Disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Four hours 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 19 57 , to Feb. 6, 19 59 , that I last saw the deceased alive on Feb. 6, 19 59 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lynwood Heiges				ADDRESS (Street, city or town, state) 6940 Piney Branch Rd. 2/7/59			
PHYSICIAN'S NAME (Type) LYNWOOD HEIGES, M.D. F.A.C.A.				DATE SIGNED Wash. D.C. NW.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY MacPelah Cemetery		22d. LOCATION (City, town, or county) (State) Lititz, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Wagner E. Humphrey, Inc., Silver Spring, Md. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE FEB 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2059

CERTIFICATE OF DEATH

Reg. Dist. No.

02032

1. PLACE OF DEATH a. COUNTY <u>Montg. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>15 Da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Alexandria</u> Last <u>Gloyd</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>5th</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12-1897</u>
9. AGE (In years last birthday) <u>61 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>111</u>	
11. BIRTHPLACE (State or foreign country) <u>Montg. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Samuel Arthur Gloyd</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Clements</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>war 42</u>		16. SOCIAL SECURITY NO. <u>214 03 8178</u>	
17. INFORMANT <u>Mary Ellen Gloyd.</u> Address <u>Germantown, Rural</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage</u> <u>260x</u> DUE TO <u>Cause Undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis - as manifested by Left hemiplegia</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 23</u> , 19 <u>59</u> , to <u>Feb. 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>59</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gaithersburg, Md.</u> DATE SIGNED <u>2-5-59</u>			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Rose.</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Rural, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> ADDRESS <u>Gaithersburg, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>	

2060

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. STATE Washington D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5926 -13 th Place N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ellen (NEEL) L Glyn				4. DATE OF DEATH Month Day Year Feb 4 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/87	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Huron County, Norwalk, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Patrick J. Cahill		14. MOTHER'S MAIDEN NAME ELLEN CONNERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MARGARET GLYNN - (Above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Sigmoid Colon 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thromboses, Fracture rt hip				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-15-58 , 19____, to 19____, that I last saw the deceased alive on 2-2-59 , 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew J. Bell M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 5412 Colo. Ave N.W. Wash. D.C.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-59		22c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		22d. LOCATION (City, town, or county) (State) Toledo Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home ADDRESS 4812 2nd Ave N.W.				24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2061
CERTIFICATE OF DEATH

Reg. Dist. No.

12034

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING Home</u>		d. STREET ADDRESS <u>2216-8th St NW</u>	
3. NAME OF DECEASED (Type or print) <u>Dinah</u> First Middle Last <u>GORDAN</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2</u> 9. AGE (In years last birthday) <u>88</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Ralph Gordon</u> Address <u>420 Maple Pike Silver Spring</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Clonus of rectum</u> (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 mins.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. j. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>47</u> , to <u>Feb. 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 26</u> , 19 <u>59</u> , and that death occurred at <u>1:55</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon C. Weiner MD</u> M.D.		ADDRESS (Street, city or town, state) <u>100 Longfellow St N.W.</u> DATE SIGNED <u>Feb 27-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>2/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GOLDSTEINS FUN. HOME</u>	22d. LOCATION (City, town, or county) (State) <u>PHILA. PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Hse</u> ADDRESS <u>4217-9th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2062

CERTIFICATE OF DEATH

Reg. Dist. No.

02035

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Diney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Brooke Grove Chronic Hosp -</u>				d. STREET ADDRESS <u>408 Kennedy St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Harry G. Gossage</u>				4. DATE OF DEATH <u>Feb-14-1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9-1882</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter Int Decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Harry Gossage</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Frances Strawn</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>579-48-8179</u>				17. INFORMANT (Name and address) <u>Mrs. Emma Gossage (Wife) 408 Kennedy St. N.W. Washington D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>3 mos.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic duodenal ulcer</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> Month, Day, Year				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 23, 1958</u> to <u>Feb. 14, 1959</u> that I last saw the deceased alive on <u>Feb 5, 1959</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Spencer</u> M.D.				DATE SIGNED <u>Columbia Road</u>			
PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>				<u>Burtonsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVal</u> ADDRESS <u>2224 W. 10th Ave. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

CERTIFICATE OF DEATH

1985

NAME OF DECEASED <i>JOHN J. SMITH</i>		DATE OF DEATH <i>10/15/85</i>	
AGE <i>68</i>		SEX <i>M</i>	
RACE <i>W</i>		EDUCATION <i>HS</i>	
MARRIAGE <i>1</i>		OCCUPATION <i>RETIRED</i>	
PLACE OF BIRTH <i>NEW YORK</i>		PLACE OF DEATH <i>HOME</i>	
DATE OF BIRTH <i>10/15/17</i>		TIME OF DEATH <i>10:00 AM</i>	
CAUSE OF DEATH <i>HEART DISEASE</i>		MANNER OF DEATH <i>NATURAL</i>	
IMMEDIATE CAUSE <i>MYOCARDIAL INFARCTION</i>		UNDERLYING CAUSE <i>ATHEROSCLEROSIS</i>	
MORBIDITY <i>NO</i>		MORTALITY <i>NO</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>	
DATE OF SIGNATURE <i>10/15/85</i>		DATE OF SIGNATURE <i>10/15/85</i>	

2063

CERTIFICATE OF DEATH

02036

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1606 Highland, Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse P. Greenstein</u>				4. DATE OF DEATH Month Day Year <u>February 12 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1902</u>	9. AGE (In years last birthday) <u>56 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctbr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research</u>		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Greenstein</u>				14. MOTHER'S MAIDEN NAME <u>Lena Bernbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife</u> <u>Mrs. Lucy L. Greenstein</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE LT. INTRACEREBRAL Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe</u>				ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md.</u>		DATE SIGNED <u>2/12/59</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 13, 1959</u>		22c. NAME OF CEMETERY OR-CREMATORY <u>King David Memorial Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belamansky Sons</u>				ADDRESS <u>3501-14 St NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02037

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkview</u> ✓			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>mt Airy</u> (rural) ✓		
c. LENGTH OF STAY IN 1b <u>2.0 A.</u>			d. STREET ADDRESS <u>Rt 1 #3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co Gen. Hosp</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Ernest Wilson Grimes</u>			4. DATE OF DEATH <u>2-21-1959</u>		
5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-6-98</u>		
9. AGE (In years last birthday) <u>60</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		
11. BIRTHPLACE (State or foreign country) <u>md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>		
13. FATHER'S NAME <u>Tom Grimes</u>			14. MOTHER'S MAIDEN NAME <u>Anna Jane Beall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>579055354</u>		
17. INFORMANT <u>Mary Grimes (wife)</u>			Address <u>Item 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb. 24, 59</u>			22b. DATE THEREOF		
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>			22d. LOCATION (City, town, or county) (State) <u>Browningsville Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>			ADDRESS <u>Laytonsville, Md</u>		
24a. REC'D BY REGISTRAR <u>FEB 25 '59</u>			DATE		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2065

CERTIFICATE OF DEATH

Reg. Dist. No.

02038

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ropine Nursing Home</u>				d. STREET ADDRESS <u>4600 49th Street, N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRED PRESTON GUTHRIE</u>				4. DATE OF DEATH Month Day Year <u>Feb 6 19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Communications</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Radio Corp. of America</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Walter Craig Guthrie</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Lyle Gilkeson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>LeBron Guthrie</u>				Address <u>4600 49th St. N.W., Washington D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subacute Bacterial Endocarditis</u> 9 mos DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-1</u> , 195 <u>9</u> , to <u>2-6</u> , 195 <u>9</u> , that I last saw the deceased alive on <u>2-2</u> , 195 <u>9</u> , and that death occurred at <u>7:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hill Carter</u> M.D. <u>1835 Eye St NW</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>HILL CARTER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tinkleing Springs Pres. Church</u>		22d. LOCATION (City, town, or county) (State) <u>Fishersville, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Lee</u>				ADDRESS <u>2847 Wilson Blvd. Arlington, Va.</u>		24a. REC'D BY REGISTRAR <u>9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

2066

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		1. d. STREET ADDRESS Edison Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROLYN ANN HALL		4. DATE OF DEATH Month Day Year February 27, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 5, 1954
9. AGE (In years lost birthday) yrs. 5		IF UNDER 1 YEAR Months Days Hours Min. 0 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William G. Hall		14. MOTHER'S MAIDEN NAME Anna Hartman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
INFORMANT Wm. G. Hall-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Acute Lymphatic Leukemia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5 , 19 59 , to Feb. 27 , 19 59 , that I last saw the deceased alive on Feb. 27 , 19 59 , and that death occurred at 5th P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 615 W. Montgomery Ave DATE SIGNED 2/28/59 ACTUAL SIGNATURE Stephen C. Cromwell M.D. PHYSICIAN'S NAME (Type) Stephen C. Cromwell, M.D. Rockville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

02040

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>18 days</u> x <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>15704 Huntington Rk.</u>			
3. NAME OF DECEASED (Type or print) <u>Fredric Albert</u> First Middle Last				4. DATE OF DEATH <u>FEB</u> Month Day Year <u>2</u> <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13-1905</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>management</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publishing</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ray Hamlin</u>				14. MOTHER'S MAIDEN NAME <u>Clarke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Margaret Hamlin</u> Address <u>5704 Huntington Pk.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leukemia, myelogenous</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH: <u>20 min</u> <u>11 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>7 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7 Feb</u> , 19 <u>59</u> , and that death occurred at <u>5:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave</u> DATE SIGNED <u>7 Feb 59</u>							
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> M.D.				PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u> <u>Bethesda, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>2/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>FEB 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Colton S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2068

CERTIFICATE OF DEATH

Reg. Dist. No.

02041

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belmont Farm Convalescent Home		d. STREET ADDRESS 1701 Park Road, N.W.	
3. NAME OF DECEASED (Type or print) Emma Hammerstein		4. DATE OF DEATH Month 2 - Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1880
9. AGE (In years lost birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Mathis		14. MOTHER'S MAIDEN NAME Rebecca Bukofzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Gerhard Hammerstein-10038 Renfrew Rd., S.S., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/2/59 , 19 58 to 7/5/59 , 19 59 , that I last saw the deceased alive on 7/3/59 , 19 59 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE J. W. Bird M.D. Sandy Spring, Md. PHYSICIAN'S NAME (Type) J. W. Bird, M.D. ADDRESS Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2069

CERTIFICATE OF DEATH

Reg. Dist. No. 02042

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle M. Last HARDING		4. DATE OF DEATH Month Feb. Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/14
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ray Hammond		14. MOTHER'S MAIDEN NAME Unknown Catherine Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Dean H. Harding, M.D. (same as #2)	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized metastatic Carcinoma (c) Carcinoma Colon		INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 years 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
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21. I certify that I attended the deceased from **March, 1956**, to **Feb. 20, 1959**, that I last saw the deceased alive on **Feb. 20, 1959**, and that death occurred at **7:26 AM**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE **C. Willard Camalier, Jr., M.D.** **1801 - Eye St. N.W. Wash. D.C. 2/20/59**

PHYSICIAN'S NAME (Type) **C. WILLARD CAMALIER, JR.**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 23, 1959	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Montgomery County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St. N.W. D.C.		24a. REC'D BY REGISTRAR DATE FEB 24 59	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1992 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02043

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. LENGTH OF STAY IN 1b <u>17</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7411 Hancock Ave</u>				d. STREET ADDRESS <u>7411 Hancock Ave Apt. 303</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MRS GLADYS L. HARRISON</u>				4. DATE OF DEATH <u>FEB 3 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 28, 1902</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Internal Revenue</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel E. Rely</u>				14. MOTHER'S MAIDEN NAME <u>Emma Balderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>WV 1</u>		17. INFORMANT <u>Mrs. J. A. Jordan, 1211 Paruch Dr. - Rockville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>on living room floor</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been dead several days when found.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/6/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carraway Dr NW</u>				24a. REC'D BY REGISTRAR <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kirsch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2070

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY The District of Columbia 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 34 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1016 49th Street, N. E.			
3. NAME OF DECEASED (Type or print) First Middle Last Alice Luticia Hawkins				4. DATE OF DEATH Month Day Year February 17, 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 14, 1908	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thurman Watkins				14. MOTHER'S MAIDEN NAME Lucinda Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 010X Tuberculous Meningitis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 14, 1959 , to February 17, 1959 , that I last saw the deceased alive on February 17, 1959 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 2-18-59 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Albert Treger M.D.				PHYSICIAN'S NAME (Type) Albert Treger, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee P. Palmer				ADDRESS 412 H St, N.E. Washington D.C.		24a. REC'D BY REGISTRAR FEB 19 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02045

2071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 129 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 447 University Boulevard, East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton		Middle Francis		Last Heffernan		4. DATE OF DEATH Month February	
Day 16,		Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1917		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget Examiner		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Heffernan				14. MOTHER'S MAIDEN NAME Mary Flaherty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-09-4586		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest followed by Cardiac Arrest DUE TO (b) Increased Intracranial Pressure DUE TO Adenocarcinoma, Primary Undetermined, with (c) Metastasis to Cerebellum and Lung.						INTERVAL BETWEEN ONSET AND DEATH Minutes Months Years Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1958 , to February 16, 1959 , that I last saw the deceased alive on February 16, 1959 , and that death occurred at 8:29 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-17-59							
ACTUAL SIGNATURE G. Milton Shy		M.D. G. Milton Shy, M. D.		National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/20/59		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2021

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1953	
5. PLACE OF BIRTH Baltimore, Maryland		6. RACE White		7. OCCUPATION Retired		8. MARITAL STATUS Married	
9. DATE OF DEATH 10/15/2021		10. TIME OF DEATH 10:00 AM		11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. DISEASE OR INJURY Myocardial Infarction		14. PERMANENT RESIDENCE 1234 Elm St, Baltimore, MD 21201		15. TEMPORARY RESIDENCE None		16. US BIRTHPLACE Maryland	
17. US DEATHPLACE Maryland		18. FOREIGN BIRTHPLACE None		19. FOREIGN DEATHPLACE None		20. FOREIGN RESIDENCE None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF WITNESS None		23. SIGNATURE OF PHYSICIAN None		24. SIGNATURE OF REGISTRAR None	
25. DATE OF SIGNATURE None		26. TIME OF SIGNATURE None		27. PLACE OF SIGNATURE None		28. PLACE OF DEATH None	

RECEIVED
BALTIMORE
OCT 16 2021

1993

CERTIFICATE OF DEATH

Reg. Dist. No.

02046

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 15,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Everett Hendricks</u>				4. DATE OF DEATH Month Day Year <u>Feb. 2 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-93</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Examiner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kyt.</u>		11. BIRTHPLACE (State or foreign country) <u>American</u>	
13. FATHER'S NAME <u>Albert E. Hendricks</u>				14. MOTHER'S MAIDEN NAME <u>Laura Allender</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII Army</u>				16. SOCIAL SECURITY NO. <u>Pl's Chart.</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> <u>adenocarcinoma of prostate</u> DUE TO <u>prostatic hyperplasia</u> DUE TO <u>prostatic hyperplasia & Left Renal Atrophy</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos</u> <u>2 Mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-6-</u> , 19 <u>58</u> , to <u>2/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>58</u> , and that death occurred at <u>9:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>934 Elmwood Rd. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>2-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LEES CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>3004th ST NW D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Lee</u> ADDRESS <u>3004th ST NW</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Case No. 100-10000

PLACE OF BIRTH 1. Country 2. State or Territory 3. County or Parish 4. City or Town or Village or Hamlet or Precinct or Census Tract or Block		PLACE OF DEATH 1. Country 2. State or Territory 3. County or Parish 4. City or Town or Village or Hamlet or Precinct or Census Tract or Block	
DATE OF BIRTH 1. Month 2. Day 3. Year		DATE OF DEATH 1. Month 2. Day 3. Year	
SEX 1. Male 2. Female		RACE 1. White 2. Negro 3. Other	
OCCUPATION 1. Full-time 2. Part-time 3. Unemployed 4. Retired 5. Student 6. Homemaker 7. Other		CAUSE OF DEATH 1. Immediate 2. Intermediate 3. Underlying	
PLACE OF DEATH 1. Home 2. Hospital 3. Nursing Home 4. Prison 5. Other		MANNER OF DEATH 1. Natural 2. Accidental 3. Suicide 4. Homicide 5. Undetermined	
SIGNATURE OF DECEASED 1. Signature 2. Print Name		SIGNATURE OF WITNESS 1. Signature 2. Print Name	
SIGNATURE OF PHYSICIAN 1. Signature 2. Print Name		SIGNATURE OF CORONER 1. Signature 2. Print Name	
SIGNATURE OF REGISTRAR 1. Signature 2. Print Name		SIGNATURE OF CLERK 1. Signature 2. Print Name	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See Birth Certificate
1994

CERTIFICATE OF DEATH

04530

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b Washington Sanitarium and Hosp. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS Box 265 Springfield Road, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hobbs			4. DATE OF DEATH Month Day Year February 23, 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/59 @ 8:15 am	9. AGE (In years last birthday) yrs. 12	IF UNDER 1 YEAR Months Days Hours Min 12 5		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Edward Dorsey Hobbs			14. MOTHER'S MAIDEN NAME Patricia Louise Cauffman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT father Address same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity + atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 2/23 , 19 59 , to 2/23 , 19 59 , that I last saw the deceased alive on 2/23 , 19 59 , and that death occurred at 8:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8418 New Hampshire Ave., Silver Spring, Md. DATE SIGNED							
ACTUAL SIGNATURE W. G. Preisser		M.D. 8418 New Hampshire Ave., Silver Spring, Md.					
PHYSICIAN'S NAME (Type) W. G. Preisser, M. D.		M.D. 8418 New Hampshire Ave., Silver Spring, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2-25-59	22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hosp. Takoma Park, Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D.		ADDRESS Washington Sanitarium and Hosp. Takoma Park, Maryland		24a. REC'D BY REGISTRAR APR 24 1959 24b. REGISTRAR'S SIGNATURE			

2075 253XVV

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

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1 *4*
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 16-DE</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5404 Blackstone Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Julian Lawrence Holley</i>		4. DATE OF DEATH <i>Feb 22 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-25-'98</i>
9. AGE (In years last birthday) <i>60 yrs.</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mathematics</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>APPLIED PHYSICS LAB Comm</i>	
11. BIRTHPLACE (State or foreign country) <i>Ill. S.C.</i>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <i>Julian R. Holley</i>		14. MOTHER'S MAIDEN NAME <i>Calista Brackett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Helen Holley (wife)</i>		Address <i>Stur 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (b) <i>sudden</i> (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>History of previous coronary disease</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>2/26/1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Newton Crematorium</i>		22d. LOCATION (City, town, or county) (State) <i>Newton, Mass</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Kaulers Sons, 1756 Pa. Ave. N. W. C.</i>		24a. REC'D BY REGISTRAR <i>FEB 24 59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Calvin S. Frame</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1993 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02048

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 49 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7200 Holly Ave.				d. STREET ADDRESS 7200 Holly Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Humphrey Sr.				4. DATE OF DEATH Month Feb. Day 4, Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1877		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Humphrey				14. MOTHER'S MAIDEN NAME Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Adelia H. Frazier Address Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/5/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Georg Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Galters, 254 Carroll St NW DC				24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56 d. STREET ADDRESS 1606 Brisbane Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Lincoln HUMPHREYS				4. DATE OF DEATH Month Day Year February 4 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-27-20	
9. AGE (In years last birthday) 38 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Engineer		10b. KIND OF BUSINESS OR INDUSTRY Federal Aviation Ag.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lincoln HUMPHREYS		14. MOTHER'S MAIDEN NAME Julia YOUNGQUIST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT (W) Mrs. Mary Louise Humphreys, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma with metastasis 190.5 DUE TO (Primary site: left scapula region) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 23, 1959 , to February 4, 1959 , that I last saw the deceased alive on February 4, 1959 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 2-4-59							
ACTUAL SIGNATURE Robert C. Thomas		PHYSICIAN'S NAME (Type) R. C. THOMAS, LT, MC, USN Bethesda 14, Maryland					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey ADDRESS R.A. Humphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE FEB 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1918-10-15	
Place of Birth		Cause of Death		Occupation		Residence	
New York City		Pneumonia		Teacher		123 Main St, Baltimore	
Date of Birth		Time of Death		Place of Death		Physician	
1873-05-20		10:30 AM		Home		Dr. J. Smith	
Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Natural		[Signature]		[Signature]		[Signature]	
Buried or Interred		Name of Burial Place		Name of Minister		Name of Undertaker	
Yes		St. Mary's Church		Rev. Mr. Jones		Mr. White	
Name of Burial Place		Name of Minister		Name of Undertaker		Name of Coroner	
Greenwood Cemetery		Rev. Mr. Jones		Mr. White		Mr. Black	
Name of Coroner		Name of Registrar		Name of Physician		Name of Burial Place	
Mr. Black		Mr. White		Dr. J. Smith		St. Mary's Church	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2074

CERTIFICATE OF DEATH

Reg. Dist. No.

02050

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME				e. STREET ADDRESS 56 SILVER SPRING 1 508 MISSISSIPPI AVENUE			
d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle ROBERTA Last HUNTER				4. DATE OF DEATH Month FEB. Day 27 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Stationary Store		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ROBERT H. HUNTER				14. MOTHER'S MAIDEN NAME MARY FRANCES NOLLAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Virginia E. Rowe, 508 Mississippi Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute Cardiovascular Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiovascular Dis (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 7 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1, 1955 , to Feb. 27, 1959 , that I last saw the deceased alive on Feb 26, 1959 , and that death occurred at 2:50 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John S. Rogers M.D. 1919 Pennsylvania 120 2-27-59							
PHYSICIAN'S NAME (Type) JOHN S. ROGERS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/2/59		22c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. POMPHREY, INC. Raymond E. Zicka				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. RACE White		5. BIRTH DATE 1885		6. BIRTH PLACE Maryland	
7. DECEASED DATE 1950		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED SYMPTOMS Chest pain, shortness of breath	
13. DECEASED MEDICAL HISTORY Hypertension, Diabetes		14. DECEASED TREATMENT Medication, Surgery		15. DECEASED SURVIVAL No	
16. DECEASED BURIAL PLACE Catholic Cemetery		17. DECEASED BURIAL DATE 1950		18. DECEASED BURIAL TIME 10:00 AM	
19. DECEASED BURIAL PLACE Catholic Cemetery		20. DECEASED BURIAL DATE 1950		21. DECEASED BURIAL TIME 10:00 AM	
22. DECEASED BURIAL PLACE Catholic Cemetery		23. DECEASED BURIAL DATE 1950		24. DECEASED BURIAL TIME 10:00 AM	
25. DECEASED BURIAL PLACE Catholic Cemetery		26. DECEASED BURIAL DATE 1950		27. DECEASED BURIAL TIME 10:00 AM	
28. DECEASED BURIAL PLACE Catholic Cemetery		29. DECEASED BURIAL DATE 1950		30. DECEASED BURIAL TIME 10:00 AM	
31. DECEASED BURIAL PLACE Catholic Cemetery		32. DECEASED BURIAL DATE 1950		33. DECEASED BURIAL TIME 10:00 AM	
34. DECEASED BURIAL PLACE Catholic Cemetery		35. DECEASED BURIAL DATE 1950		36. DECEASED BURIAL TIME 10:00 AM	
37. DECEASED BURIAL PLACE Catholic Cemetery		38. DECEASED BURIAL DATE 1950		39. DECEASED BURIAL TIME 10:00 AM	
40. DECEASED BURIAL PLACE Catholic Cemetery		41. DECEASED BURIAL DATE 1950		42. DECEASED BURIAL TIME 10:00 AM	
43. DECEASED BURIAL PLACE Catholic Cemetery		44. DECEASED BURIAL DATE 1950		45. DECEASED BURIAL TIME 10:00 AM	
46. DECEASED BURIAL PLACE Catholic Cemetery		47. DECEASED BURIAL DATE 1950		48. DECEASED BURIAL TIME 10:00 AM	
49. DECEASED BURIAL PLACE Catholic Cemetery		50. DECEASED BURIAL DATE 1950		51. DECEASED BURIAL TIME 10:00 AM	
52. DECEASED BURIAL PLACE Catholic Cemetery		53. DECEASED BURIAL DATE 1950		54. DECEASED BURIAL TIME 10:00 AM	
55. DECEASED BURIAL PLACE Catholic Cemetery		56. DECEASED BURIAL DATE 1950		57. DECEASED BURIAL TIME 10:00 AM	
58. DECEASED BURIAL PLACE Catholic Cemetery		59. DECEASED BURIAL DATE 1950		60. DECEASED BURIAL TIME 10:00 AM	
61. DECEASED BURIAL PLACE Catholic Cemetery		62. DECEASED BURIAL DATE 1950		63. DECEASED BURIAL TIME 10:00 AM	
64. DECEASED BURIAL PLACE Catholic Cemetery		65. DECEASED BURIAL DATE 1950		66. DECEASED BURIAL TIME 10:00 AM	
67. DECEASED BURIAL PLACE Catholic Cemetery		68. DECEASED BURIAL DATE 1950		69. DECEASED BURIAL TIME 10:00 AM	
70. DECEASED BURIAL PLACE Catholic Cemetery		71. DECEASED BURIAL DATE 1950		72. DECEASED BURIAL TIME 10:00 AM	
73. DECEASED BURIAL PLACE Catholic Cemetery		74. DECEASED BURIAL DATE 1950		75. DECEASED BURIAL TIME 10:00 AM	
76. DECEASED BURIAL PLACE Catholic Cemetery		77. DECEASED BURIAL DATE 1950		78. DECEASED BURIAL TIME 10:00 AM	
79. DECEASED BURIAL PLACE Catholic Cemetery		80. DECEASED BURIAL DATE 1950		81. DECEASED BURIAL TIME 10:00 AM	
82. DECEASED BURIAL PLACE Catholic Cemetery		83. DECEASED BURIAL DATE 1950		84. DECEASED BURIAL TIME 10:00 AM	
85. DECEASED BURIAL PLACE Catholic Cemetery		86. DECEASED BURIAL DATE 1950		87. DECEASED BURIAL TIME 10:00 AM	
88. DECEASED BURIAL PLACE Catholic Cemetery		89. DECEASED BURIAL DATE 1950		90. DECEASED BURIAL TIME 10:00 AM	
91. DECEASED BURIAL PLACE Catholic Cemetery		92. DECEASED BURIAL DATE 1950		93. DECEASED BURIAL TIME 10:00 AM	
94. DECEASED BURIAL PLACE Catholic Cemetery		95. DECEASED BURIAL DATE 1950		96. DECEASED BURIAL TIME 10:00 AM	
97. DECEASED BURIAL PLACE Catholic Cemetery		98. DECEASED BURIAL DATE 1950		99. DECEASED BURIAL TIME 10:00 AM	
100. DECEASED BURIAL PLACE Catholic Cemetery		101. DECEASED BURIAL DATE 1950		102. DECEASED BURIAL TIME 10:00 AM	

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. BIRTH DATE
6. BIRTH PLACE
7. DECEASED DATE
8. DECEASED TIME
9. DECEASED PLACE
10. DECEASED CAUSE
11. DECEASED DISEASE
12. DECEASED SYMPTOMS
13. DECEASED MEDICAL HISTORY
14. DECEASED TREATMENT
15. DECEASED SURVIVAL
16. DECEASED BURIAL PLACE
17. DECEASED BURIAL DATE
18. DECEASED BURIAL TIME
19. DECEASED BURIAL PLACE
20. DECEASED BURIAL DATE
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100. DECEASED BURIAL PLACE
101. DECEASED BURIAL DATE
102. DECEASED BURIAL TIME

TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2075

CERTIFICATE OF DEATH

Reg. Dist. No.

02051

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1819 North Fairfax Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle Elizabeth Last Husbands				4. DATE OF DEATH Month February Day 12 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Benjamin Chiffins				14. MOTHER'S MAIDEN NAME Emily Ellen James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelogenous leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute hemorrhagic pneumonia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Bronchiectasis 2. Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Months Days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 28, 1959 , to February 12, 1959 , that I last saw the deceased alive on February 12, 1959 , and that death occurred at 4:05 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-13-59 ACTUAL SIGNATURE Arthur T. Teplitzky M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-15-59		22c. NAME OF CEMETERY OR CREMATORY Silver Brook		22d. LOCATION (City, town, or county) (State) Wilmington Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. [Signature]				24a. REC'D BY REGISTRAR Feb 16 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

Page Two

1. NAME OF DECEASED JAMES T. LEBLANC, JR.		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1923		5. PLACE OF BIRTH New Orleans, Louisiana	
6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1945		9. PLACE OF MARRIAGE New Orleans, Louisiana		10. NAME OF SPOUSE Mary L. LeBlanc	
11. PRESENT RESIDENCE 1234 Main St., New Orleans, Louisiana		12. DATE OF DEATH 1958		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Acute myocardial infarction		15. MEDICAL HISTORY Hypertension	
16. NAME OF PHYSICIAN Dr. J. H. Smith		17. NAME OF HOSPITAL St. Mary's Hospital		18. NAME OF NURSE Mrs. J. K. Brown		19. NAME OF CORONER Mr. A. B. White		20. NAME OF BURIAL PLACE Holy Sepulchre Cemetery	
21. SIGNATURE OF PHYSICIAN J. H. Smith		22. SIGNATURE OF HOSPITAL St. Mary's Hospital		23. SIGNATURE OF NURSE Mrs. J. K. Brown		24. SIGNATURE OF CORONER Mr. A. B. White		25. SIGNATURE OF BURIAL PLACE Holy Sepulchre Cemetery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BALTIMORE, 18														
MARYLAND STATE DEPARTMENT OF HEALTH														
CERTIFICATE OF DEATH														
Reg. Dist. No.														
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					1. STREET ADDRESS <u>9208 Adelaide Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rose</u> Last <u>Jodice</u>					4. DATE OF DEATH		Month <u>2</u> Day <u>1</u> Year <u>1959</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 24, 1898</u>		9. AGE (In years last birthday) <u>61</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Dominic Jozzo</u>					14. MOTHER'S MAIDEN NAME <u>Filomena Yelardo</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>Sen. Carmen Joseph Jodice</u> Address <u>—</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> 199.2 DUE TO <u>Primary site unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1958</u>		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>58</u> , to <u>Feb 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.														
ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D.					ADDRESS (Street, city or town, state) <u>8601 old Georgetown Rd</u> DATE SIGNED <u>—</u>									
PHYSICIAN'S NAME (Type) <u>Allen J O'Neill</u>					Bethesda 19 Md									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>2/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>			22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda, Maryland</u> ADDRESS <u>—</u>					24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>							

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tem 18 Film 238 2-13-59 ams Item 8 Film 239 2-25-59 et

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2077

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02052

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 27 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 x -3 d. STREET ADDRESS 4344 Texas Ave., S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle IRVING Last IRVING				4. DATE OF DEATH Month February Day 23 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-94	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 705-01-0801		17. INFORMANT (W) Mrs. Florence Irving, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Constrictive Pericarditis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 min. 12 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 27, 1959 , to February 23, 1959 , that I last saw the deceased alive on February 23, 1959 , and that death occurred at 10:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2-24-59							
ACTUAL SIGNATURE R. G. Muth		PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-59	22c. NAME OF CEMETERY OR CREMATORY New Mount Baptist Church		22d. LOCATION (City, town, or county) (State) Arrington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co., 901 3rd St., S.W. Wash., DC			24a. REC'D BY REGISTRAR DATE FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Rhines		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2078

CERTIFICATE OF DEATH

Reg. Dist. No.

02053

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Amherst c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Amherst 83X-3 d. STREET ADDRESS General Delivery e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Reuben Pettice Iseman			4. DATE OF DEATH Month Day Year February 26, 1959		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 21, 1914		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Link Iseman		
14. MOTHER'S MAIDEN NAME Alice Staples			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 225-28-8421			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar and Lobular Pneumonitis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Carcinoid with widespread Metastases DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 Days Years					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from February 23, 1959 , to February 26, 1959 , that I last saw the deceased alive on February 26, 1959 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 2-26-59 National Institutes of Health Bethesda 14, Maryland					
ACTUAL SIGNATURE Eugene B. Feigelson M.D. PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/59		22c. NAME OF CEMETERY OR CREMATORY Amherst Cemetery	
22d. LOCATION (City, town, or county) (State) Amherst, Virginia.		23. FUNERAL DIRECTOR'S SIGNATURE Wm. Demaine & Son Funeral Home, Alexandria, Va. W. H. Demaine Jr.		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur A. Frawley					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2079

CERTIFICATE OF DEATH

02054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Roanoke			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2321 Garden City Boulevard, SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Odell Last Janison				4. DATE OF DEATH Month February Day 7 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 9, 1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.		IF UNDER 24 HRS. Months 44 Days 44 Hours 44 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Daniel Starkey				14. MOTHER'S MAIDEN NAME Lana Guthrie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Undascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast c Metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 22, 19 58 , to February 7, 19 59 , that I last saw the deceased alive on February 7, 19 59 , and that death occurred at 9:55a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-7-59 ACTUAL SIGNATURE Jack Levin M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Jack Levin, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial Feb. 9-59		Feb. 9-59		Blue Ridge Memorial Park		Roanoke - Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Watson Funeral Home Horton L. Watson				ADDRESS 395 Wash Ave. VINTON - Va.		24a. REC'D BY REGISTRAR FEB 16 '59 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG239 3-13-59 et

2080

CERTIFICATE OF DEATH

Reg. Dist. No. 215

n2055

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 708 4th Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Albert Leon JONES				4. DATE OF DEATH Month Day Year February 5 19 59											
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-7-80 1890		9. AGE (In years last birthday) 68 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government				11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Sahrah TUTT				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 577-16-0730		17. INFORMANT (W) Mrs. Gladys Jones, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coroniosclerotic Heart DUE TO (c) Disease										INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 3, 1959 , to February 5, 1959 , that I last saw the deceased alive on February 4, 1959 , and that death occurred at 12:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 2-5-59															
ACTUAL SIGNATURE R. G. Muth				PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) (State) Belington Va.					
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis						ADDRESS 1432 U St. NW, Washington, DC				24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2081

CERTIFICATE OF DEATH

Reg. Dist. No.

02056

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unity</u> (Rural)		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unity</u> (Rural)	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
13. FATHER'S NAME <u>Cornelius Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cassell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Laura Howard:</u>		Address <u>Brookeville, Md. R. F. D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia</u> <u>442x</u> DUE TO <u>Arteriosclerotic Cardiorenal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inguinal Hernia.</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 7, 1955</u> to <u>Feb. 8, 1959</u> , that I last saw the deceased alive on <u>Feb. 7, 1959</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2-10-59</u>			
ACTUAL SIGNATURE <u>Webster Sewell</u>		M.D. _____	
PHYSICIAN'S NAME (Type) <u>Webster Sewell, M.D.</u>		Rt. 1 Silver Spring, Md.	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Reburied</u>		22b. DATE THEREOF <u>2/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>
22d. LOCATION (City, town, or county) <u>Rockville, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanks</u>	

CERTIFICATE OF DEATH

File No. 100

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
DECEASED		M		27		JAN 1 1900		BALTIMORE, MARYLAND	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		MEDICINE		NO	
DATE OF DEATH		PLACE OF DEATH		OCCUPATION		EDUCATION		RELIGION	
JAN 1 1927		BALTIMORE, MARYLAND		CLERK		HIGH SCHOOL		METHODIST	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF MARRIAGE		SIGNATURE OF BURIAL	
J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 1 1927		JAN 1 1927		JAN 1 1927		JAN 1 1927		JAN 1 1927	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2082

CERTIFICATE OF DEATH

Reg. Dist. No.

02057

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 42 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheeling			
f. STREET ADDRESS 214 Warwood Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theodore Middle Allen Last Kavrakis				4. DATE OF DEATH Month February Day 15 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15, 1956	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Theodore Kavrakis				14. MOTHER'S MAIDEN NAME Shirley Harwatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 200.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malignant lymphoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-15-59							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 4, 19 59 , to February 15, 19 59 , that I last saw the deceased alive on February 15, 19 59 , and that death occurred at 9:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-15-59 ACTUAL SIGNATURE James M. Marsh M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) James M. Marsh, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL, SPECIES		22b. DATE THEROF 2/16/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Wheeling, W Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE FEB 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

Robert A. Humphrey-Baltimore, Maryland

3/18/60 Baltimore

Wheeling, W. Virginia

James A. ...

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

2083

CERTIFICATE OF DEATH

Reg. Dist. No.

02058

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3210 Woodhollow Drive			
3. NAME OF DECEASED (Type or print) First Mary - Middle Evelyn Last Kay				4. DATE OF DEATH Month February Day 11 Year 19 59			
5. SEX Female	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1898	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 0 Days 28 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) Louisiana, U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Cullem W. Kay				14. MOTHER'S MAIDEN NAME Emily N. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wm. P. Weber-346 Luhman, Milford, N. J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism of the Cerebellar Artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb , 19 57 , to Jan , 19 59 , that I last saw the deceased alive on Jan Feb 11 , 19 59 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 4890 Battery Lane, Bethesda 3/4/59			
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut				4890 Battery Lane, Beth. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/13/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

Covered Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2084

CERTIFICATE OF DEATH

Reg. Dist. No.

02054

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tandover. (Kent Village 16x-2)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>7213 Hawthorne Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>Christopher Joseph Keller</u>		4. DATE OF DEATH <u>March 19 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1873</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. City</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jennie Keller</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records - Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute virus Influenza + Pneumonia</u> 480x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute Pyogenic Pharyngitis - secondary</u> DUE TO <u>Co of Pharynx + Lachryal Throat + Metastasis</u> (c) <u>Indurated Pharynx from X-Ray makes Inf. Non Responsive to Therapy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 June 1956</u> to <u>2-19-1959</u> , that I last saw the deceased alive on <u>14 Feb 1959</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, State) <u>Olney, Md</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Santhland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>		ADDRESS <u>131-11 St Wash. DC</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Mattingly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2085 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 1293 Brentwood Rd, N.E. - Apt 2D		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fred		First Middle Colburn		Last KELLY		4. DATE OF DEATH Month February	
						Day 18	
						Year 1959	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-95	
						9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles KELLY		14. MOTHER'S MAIDEN NAME Julia Bell LEE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 578-32-6528		17. INFORMANT (W) Patrice Kelly, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 141.9. Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Adenocarcinoma, tongue DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 30, 1958, to February 18, 1959, that I last saw the deceased alive on February 18, 1959, and that death occurred at 4:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Troy		M.D. U. S. Naval Hospital, NNMC		ADDRESS (Street, city or town, state) Bethesda 14, Maryland		DATE SIGNED 2-19-59	
PHYSICIAN'S NAME (Type) J. W. TROY, CDR, MC, USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-24-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St., NW, Wash, D.C.		ADDRESS 24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. King			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 12-12-12-12

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

CERTIFICATE OF DEATH

Reg. Dist. No.

02061

2086

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4102 Oliver Street				d. STREET ADDRESS 4102 Oliver Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last KENEALY				4. DATE OF DEATH Month 2 Day 11 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-16	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 11 Days 19 Hours 59	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISCAL ANNALIST		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. KENEALY				14. MOTHER'S MAIDEN NAME CATHERINE S. COLLINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War 2				16. SOCIAL SECURITY NO. 578 462 687			
17. INFORMANT Address MARY ALICE KENEALY Same as "D"							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 MOS. 13 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from MAR. 1, 19 58 , to FEB. 11, 19 59 , that I last saw the deceased alive on FEB. 11, 19 59 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) John H. Tuohy				ADDRESS (Street, city or town, state) 7720 WISCONSIN AVE.			
DATE SIGNED 2/11/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 2-14-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS Wash. D. C. 3821 14th. St. N.W.		24a. REC'D BY REGISTRAR DATE FEB 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Lane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

61-

Chen et al.

2087

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmore Sanitarium</u> <u>5721 Grosvenor Lane, Bethesda</u>		d. STREET ADDRESS <u>5616 Wilson Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>CARLOTA</u> Middle <u>DA COSTA</u> Last <u>KENNEDY</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1869</u>	9. AGE (In years last birthday) yrs. <u>89</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Carlos Mexia</u>			14. MOTHER'S MAIDEN NAME <u>Julia Foster</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Joyce Doyle</u> Address <u>5616 Wilson Lane, Beth.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS, GENERAL</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	

21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>55</u> , to <u>FEB</u> <u>12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEB</u> <u>12</u> , 19 <u>59</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Leo M. Curtis</u>			ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave., Bethesda, Md.</u>		
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>			DATE SIGNED <u>2/12/59</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Miss H. H. H. Co.</u>		ADDRESS <u>17014 N. 7th St.</u>	24a. REC'D BY REGISTRAR <u>FEB 16 59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1922

DATE OF DEATH

1

RECEIVED
JAN 10 1923



CERTIFICATE OF DEATH

Reg. Dist. No.

02063

2088

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>37 1/2 Hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>R.</u> Last <u>Ketay</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>White</u>		6. COLOR OR RACE <u>Female</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/9/90</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Milton Sand</u>			
14. MOTHER'S MAIDEN NAME <u>Marian (Unknown)</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>577-32-6884</u>				17. INFORMANT <u>Son Mr. Toby Jaffe</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal aortic - cause unknown</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>November 6, 1958</u> , to <u>February 26, 1959</u> , that I last saw the deceased alive on <u>February 26, 1959</u> , and that death occurred at <u>7:15 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Trau</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8237 Georgia Ave Silver Spring Md Feb 26 1959</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/27-1959</u>		<u>National Capital Nec Center</u>		<u>Washington Dc</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Baldberg Funeral Home</u>				ADDRESS <u>4217 9th Ave NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1 Germantown				d. STREET ADDRESS RFD # 1 Germantown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jessie Middle Matilda Last King				4. DATE OF DEATH Month Feb. Day 7 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1896	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William King				14. MOTHER'S MAIDEN NAME Lillian Burke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Lee M. King, RFD 1, Germantown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 3 hours 5 years						INTERVAL BETWEEN ONSET AND DEATH 3 hours 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 10, 1943 to Feb. 7, 1959 , that I last saw the deceased alive on Feb. 7, 1959 , and that death occurred at 9:30 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 2/9/59	
PHYSICIAN'S NAME (Type) James P. Kerr				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Salem Methodist		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver S. Moberg				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '59	
				24b. REGISTRAR'S SIGNATURE Carlton S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02065

2090

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comm</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>md R-109</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Thomas Russell Kinna</u>			4. DATE OF DEATH <u>Feb 8 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-33</u>		9. AGE (In years last birthday) <u>25</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto parts</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Russell Kinna</u>			14. MOTHER'S MAIDEN NAME <u>Gladys Morningstar</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or military service) <u>Yes - US Navy - 57</u>			16. SOCIAL SECURITY NO. <u>14-363574</u>		
17. INFORMANT <u>Russell Kinna</u>			Address <u>Comm md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) <u>Multiple injuries, extreme</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger or driver in car which left highway</u>			
20c. TIME OF INJURY Month, Day, Year <u>3 p.m. 2-8-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Barnesville</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-8-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>2/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) <u>Bearsville</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Helton</u>		ADDRESS <u>Barnesville, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091

CERTIFICATE OF DEATH

Reg. Dist. No.

02066

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle JANE Last KISNER		4. DATE OF DEATH Month FEBRUARY Day 26 Year 19 59		5. SEX FEMALE			
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/3/44			
9. AGE (In years last birthday) 14 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT BOWIE KISNER			
14. MOTHER'S MAIDEN NAME ROSE REBECCA EMORY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS			
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to Feb 26 , 19 59 , that I last saw the deceased alive on Feb 24 , 19 59 , and that death occurred at 6:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE R. A. Yates M.D. _____ PHYSICIAN'S NAME (Type) R. A. YATES, M. D. OLNEY, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-59		22c. NAME OF CEMETERY OR CREMATORY Babbs Church Cemetery Germantown Md			
22d. LOCATION (City, town, or county) (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE Emmett C. Garton		24a. REC'D BY REGISTRAR MAR 2 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00753

2092

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockville		c. LENGTH OF STAY IN 1b 2½ years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION River Road, Rt. 2, Rockville		e. STREET ADDRESS River Road, Rt. 2	
3. NAME OF DECEASED (Type or print) First Middle Last Philip Marion Knox		4. DATE OF DEATH Month Day Year February 1 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1879
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant--Treas.		10b. KIND OF BUSINESS OR INDUSTRY Govt. Employee	
11. BIRTHPLACE (State or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert F. Knox		14. MOTHER'S MAIDEN NAME Lucy Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-42-7832	
17. INFORMANT Address Mrs. John C. Adams, Rt. 2., Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia and Carcinoma of Prostate 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 199.2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardio-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 9 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 58 , to 1 Feb , 19 59 , that I last saw the deceased alive on 30 January , 19 59 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Cresswell, Jr.		DATE SIGNED 2029 Quo St. N.W., Wash., D.C. 2-1-59	
PHYSICIAN'S NAME (Type) W. F. Cresswell, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-59	
22c. NAME OF CEMETERY OR CREMATORY Sharon		22d. LOCATION (City, town, or county) (State) Middleburg Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Louis R. Roper		24a. REC'D BY REGISTRAR FEB 3 '59	
ADDRESS Middleburg, Va.		24b. REGISTRAR'S SIGNATURE Arthur A. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 239 2-25-59 ams
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2093
CERTIFICATE OF DEATH

02067

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 11 Salamaua Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lynda Jean KOLBAS				4. DATE OF DEATH Month Day Year February 15 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-59	
9. AGE (In years lost birthday) yrs. 6		IF UNDER 1 YEAR Months Days 6		IF UNDER 24 HRS. Hours Min. 6			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Leon R. KOLBAS				14. MOTHER'S MAIDEN NAME Mary N. O'HARE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia 053.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pseudomonas aeruginosa DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 1959 , to February 15, 1959 , that I last saw the deceased alive on February 15, 1959 , and that death occurred at 7:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David Harris				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC			
PHYSICIAN'S NAME (Type) David HARRIS, LT, MC, USN				DATE SIGNED 2-16-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave. NW, Wash., DC				24a. REC'D BY REGISTRAR DATE FEB 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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2094

CERTIFICATE OF DEATH

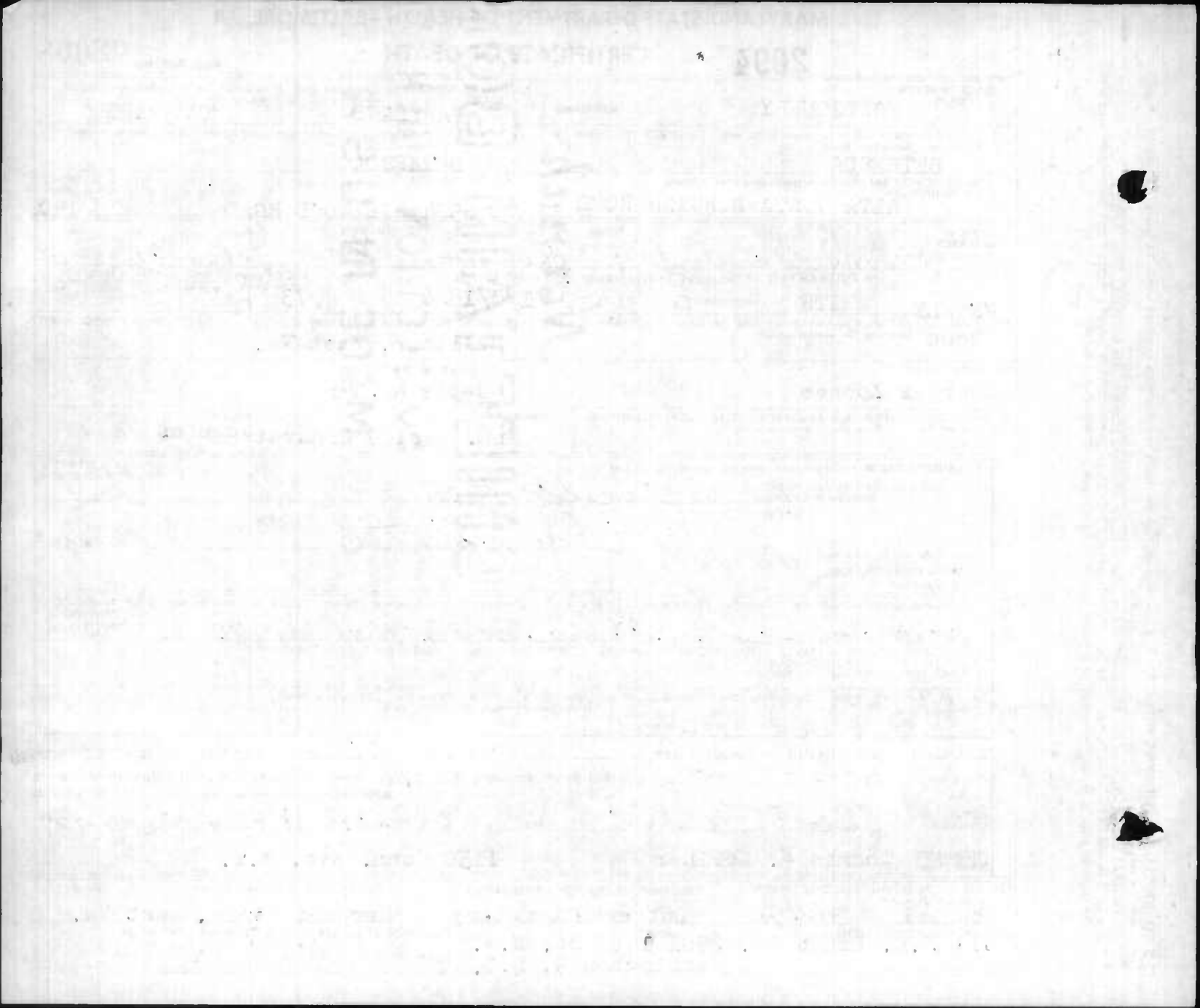
Reg. Dist. No.

02068

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTA VISTA NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maud Middle De Last Betty Koonce		4. DATE OF DEATH Month Feb. Day 26 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.	
10a. USUAL OCCUPATION (Give kind of work done or longest of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Halltown, West Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Koonce		14. MOTHER'S MAIDEN NAME Hattie Mohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Leslie Erhardt		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Acute Pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalomalacia, Cerebral Vascular Sclerosis, CASH, Polycythemia			INTERVAL BETWEEN ONSET AND DEATH 10 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1941 , to Feb 26 , 19 59 , that I last saw the deceased alive on Feb 25 , 19 59 , and that death occurred at 8:54 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thos. F. Keliher		ADDRESS (Street, city or town, state) 1150 Conn. Ave. N.W.	
PHYSICIAN'S NAME (Type) Thomas F. Keliher		DATE SIGNED 2/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/2/59	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Harpers Ferry, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2095

CERTIFICATE OF DEATH

Reg. Dist. No.

02069

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN lb 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIAS I. Middle KOZAK Last				4. DATE OF DEATH Month February Day 24 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1897		9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months 6 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Kozak				14. MOTHER'S MAIDEN NAME Pauline Saj			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 113-05-8830		INFORMANT Anne Van Meter-niece-Kensington, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma - Lung, Liver 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphosarcoma - left Kidney. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 mos. 1 year.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 21, 1959 to February 24, 1959 , that I last saw the deceased alive on February 21, 1959 , and that death occurred at 120 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave - Bethesda DATE SIGNED 2/24/59 ACTUAL SIGNATURE J. Blaine Fitzgerald M.D. J. Blaine Fitzgerald PHYSICIAN'S NAME (Type) J. Blaine Fitzgerald 8218 Wisc. Ave. Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 2/27/59		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Lewis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2093

STATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1996

CERTIFICATE OF DEATH

00754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7100 Sycamore Ave.				d. STREET ADDRESS 7100 Sycamore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle N. Last KROUT				4. DATE OF DEATH Month Feb. Day 3 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1864	
9. AGE (In years lost birthday) 94 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) Lehigh County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Snyder				14. MOTHER'S MAIDEN NAME Angelina ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mr. Russell S. Krout, 6817 5th St., N.W. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Coronary Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 48 hrs 48 hrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 2, 1959 , to Feb. 3, 1959 , that I last saw the deceased alive on Feb. 3, 1959 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles T. Carroll		ADDRESS (Street, city or town, state) 6801 6th St. N.W. Washington, D. C. DATE SIGNED 2/3/59					
PHYSICIAN'S NAME (Type) Charles T. Carroll		ADDRESS 6801 6th St. N.W. Washington, D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Vincent's Cemetery		22d. LOCATION (City, town, or county) (State) Spring City, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				ADDRESS 254 Carroll St NW DC		24a. REC'D BY REGISTRAR DATE FEB 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2096

Items 8, 9 Film 6239 3-9-57 et

Reg. Dist. No.

02070

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 Northbrook Lane			d. STREET ADDRESS 112 Northbrook Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LULA MIDDLETON LANDES			4. DATE OF DEATH Month February Day 13 , Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872 Aug. 1, 1870	9. AGE (In years last birthday) 86/38 yrs.	IF UNDER 1 YEAR Months 6 Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S					
13. FATHER'S NAME John Middleton			14. MOTHER'S MAIDEN NAME Sarah McDonald		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen Ellison	
			Address 5522 Greentree Rd Bethesda, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH sudden 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 2/16/59		22c. NAME OF CEMETERY OR CREMATORY Thorne Rose	
				22d. LOCATION (City, town, or county) (State) Staunton, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland			24a. REC'D BY REGISTRAR FEB 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kane

2

STATE OF MARYLAND
HEALTH DEPT.

2008

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOTICE TO BE FILLED BY THE MEDICAL EXAMINER		FACILITY OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF MEDICAL EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE	
15. SIGNATURE OF CLERK		16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF DISTRICT ATTORNEY		18. SIGNATURE OF COUNTY CLERK	
19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF VILLAGE CLERK	
21. SIGNATURE OF CITY CLERK		22. SIGNATURE OF TOWNSHIP CLERK	
23. SIGNATURE OF VILLAGE CLERK		24. SIGNATURE OF CITY CLERK	
25. SIGNATURE OF TOWNSHIP CLERK		26. SIGNATURE OF VILLAGE CLERK	
27. SIGNATURE OF CITY CLERK		28. SIGNATURE OF TOWNSHIP CLERK	
29. SIGNATURE OF VILLAGE CLERK		30. SIGNATURE OF CITY CLERK	
31. SIGNATURE OF TOWNSHIP CLERK		32. SIGNATURE OF VILLAGE CLERK	
33. SIGNATURE OF CITY CLERK		34. SIGNATURE OF TOWNSHIP CLERK	
35. SIGNATURE OF VILLAGE CLERK		36. SIGNATURE OF CITY CLERK	
37. SIGNATURE OF TOWNSHIP CLERK		38. SIGNATURE OF VILLAGE CLERK	
39. SIGNATURE OF CITY CLERK		40. SIGNATURE OF TOWNSHIP CLERK	
41. SIGNATURE OF VILLAGE CLERK		42. SIGNATURE OF CITY CLERK	
43. SIGNATURE OF TOWNSHIP CLERK		44. SIGNATURE OF VILLAGE CLERK	
45. SIGNATURE OF CITY CLERK		46. SIGNATURE OF TOWNSHIP CLERK	
47. SIGNATURE OF VILLAGE CLERK		48. SIGNATURE OF CITY CLERK	
49. SIGNATURE OF TOWNSHIP CLERK		50. SIGNATURE OF VILLAGE CLERK	
51. SIGNATURE OF CITY CLERK		52. SIGNATURE OF TOWNSHIP CLERK	
53. SIGNATURE OF VILLAGE CLERK		54. SIGNATURE OF CITY CLERK	
55. SIGNATURE OF TOWNSHIP CLERK		56. SIGNATURE OF VILLAGE CLERK	
57. SIGNATURE OF CITY CLERK		58. SIGNATURE OF TOWNSHIP CLERK	
59. SIGNATURE OF VILLAGE CLERK		60. SIGNATURE OF CITY CLERK	
61. SIGNATURE OF TOWNSHIP CLERK		62. SIGNATURE OF VILLAGE CLERK	
63. SIGNATURE OF CITY CLERK		64. SIGNATURE OF TOWNSHIP CLERK	
65. SIGNATURE OF VILLAGE CLERK		66. SIGNATURE OF CITY CLERK	
67. SIGNATURE OF TOWNSHIP CLERK		68. SIGNATURE OF VILLAGE CLERK	
69. SIGNATURE OF CITY CLERK		70. SIGNATURE OF TOWNSHIP CLERK	
71. SIGNATURE OF VILLAGE CLERK		72. SIGNATURE OF CITY CLERK	
73. SIGNATURE OF TOWNSHIP CLERK		74. SIGNATURE OF VILLAGE CLERK	
75. SIGNATURE OF CITY CLERK		76. SIGNATURE OF TOWNSHIP CLERK	
77. SIGNATURE OF VILLAGE CLERK		78. SIGNATURE OF CITY CLERK	
79. SIGNATURE OF TOWNSHIP CLERK		80. SIGNATURE OF VILLAGE CLERK	
81. SIGNATURE OF CITY CLERK		82. SIGNATURE OF TOWNSHIP CLERK	
83. SIGNATURE OF VILLAGE CLERK		84. SIGNATURE OF CITY CLERK	
85. SIGNATURE OF TOWNSHIP CLERK		86. SIGNATURE OF VILLAGE CLERK	
87. SIGNATURE OF CITY CLERK		88. SIGNATURE OF TOWNSHIP CLERK	
89. SIGNATURE OF VILLAGE CLERK		90. SIGNATURE OF CITY CLERK	
91. SIGNATURE OF TOWNSHIP CLERK		92. SIGNATURE OF VILLAGE CLERK	
93. SIGNATURE OF CITY CLERK		94. SIGNATURE OF TOWNSHIP CLERK	
95. SIGNATURE OF VILLAGE CLERK		96. SIGNATURE OF CITY CLERK	
97. SIGNATURE OF TOWNSHIP CLERK		98. SIGNATURE OF VILLAGE CLERK	
99. SIGNATURE OF CITY CLERK		100. SIGNATURE OF TOWNSHIP CLERK	

Robert A. Humphrey-Bolton, Maryland
Thorne Rose
Baltimore, Md.
2/18/50

2097

CERTIFICATE OF DEATH

02071

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salisbury Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Louis Langlois</u>		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Langlois</u>		14. MOTHER'S MAIDEN NAME <u>Rose Picard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>374-18-9741</u>	
17. INFORMANT <u>Wife Melba Langlois - Same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia of the lt. lung</u> DUE TO (b) <u>Carcinoma of the prostate gland & metastases</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1, 1958</u> to <u>Feb 13, 1959</u> , that I last saw the deceased alive on <u>Feb 13, 1959</u> , and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur P. Hustead</u>		ADDRESS (Street, city or town, state) <u>Washington Clinic, Wash. D. C.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR P. HUSTEAD</u>		DATE SIGNED <u>2/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6997

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS	
JAMES H. HARRIS		Male		45		10/15/1915		Baltimore, Md.		10/20/1961		Baltimore, Md.		Heart Disease		Natural		J. H. HARRIS		J. H. HARRIS	
12. OCCUPATION		13. EDUCATION		14. MARITAL STATUS		15. PREVIOUS MARRIAGES		16. PREVIOUS DEATHS		17. PREVIOUS ILLNESSES		18. PREVIOUS SURGERIES		19. PREVIOUS TRAUMAS		20. PREVIOUS ACCIDENTS		21. PREVIOUS DRUGS		22. PREVIOUS ALCOHOL	
None		None		Married		None		None		None		None		None		None		None		None	
23. PREVIOUS MENTAL ILLNESS		24. PREVIOUS PHYSICAL ILLNESS		25. PREVIOUS SURGERIES		26. PREVIOUS TRAUMAS		27. PREVIOUS ACCIDENTS		28. PREVIOUS DRUGS		29. PREVIOUS ALCOHOL		30. PREVIOUS TOBACCO		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER		37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER		49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER		61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER		73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER		77. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER		85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER		97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER		103. PREVIOUS OTHER		104. PREVIOUS OTHER		105. PREVIOUS OTHER		106. PREVIOUS OTHER		107. PREVIOUS OTHER		108. PREVIOUS OTHER		109. PREVIOUS OTHER		110. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	

ORIGINAL FILED IN 6997

2098

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 54 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Cleveland Heights				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1943 Revere Road											
3. NAME OF DECEASED (Type or print) First Arthur Middle Saul Last LANSKY				4. DATE OF DEATH Month February Day 19 Year 1959											
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-36		9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months 23		IF UNDER 24 HRS Days 19		Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Louis LANSKY				14. MOTHER'S MAIDEN NAME Nettie FIERMAN											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1956 to DOD 280-30-6605				17. INFORMANT (F) Louis Lanskay, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 179.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chorio-carcinoma origin unknown DUE TO (c) 8 months												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 27, 1958 , to February 19, 1959 , that I last saw the deceased alive on February 19, 1959 , and that death occurred at 4:25A M. from the causes and on the date stated above.															
ACTUAL SIGNATURE Jack D. Real				ADDRESS (Street, city or town, state) U. S. Naval Hospital				DATE SIGNED 2-19-59							
PHYSICIAN'S NAME (Type) Jack D. REAL, LT, MC, USN				Bethesda, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 2-19-59				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY Mount Olive				22d. LOCATION (City, town, or county) (State) Cleveland Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home				ADDRESS 4748 Wisc. Ave., NW, Wash. DC				24a. REC'D BY REGISTRAR DATE FEB 24 '59				24b. REGISTRAR'S SIGNATURE Arthur S. H...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02073

2099

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12321 Dewey Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>12321 Dewey Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Corn. Layshon Lemaster</u>		4. DATE OF DEATH <u>Feb 9 1959</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1929</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>14</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		12. KIND OF BUSINESS OR INDUSTRY <u>DC</u>	
13. BIRTHPLACE (State or foreign country) <u>DC</u>		14. CITIZEN OF WHAT COUNTRY <u>N-Sa</u>	
15. FATHER'S NAME <u>Webster H. Layshon</u>		16. MOTHER'S MAIDEN NAME <u>Richard Chadwick</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>Unknown</u>	
19. INFORMANT <u>Richard Lemaster</u>		20. ADDRESS <u>Stem 2</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hanging</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck in basement of her home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES A. BROWN		45		M		W		JAN 15 1950	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. MAIN ST.		Carpenter		Heart Disease		Natural		Home	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARITAL STATUS		RELIGION	
JAN 15 1905		BALTIMORE, MD.		High School		Married		Roman Catholic	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		POST-MORTEM FINDINGS		LABORATORY TESTS		TOXICOLOGY	
None		Chest pain, shortness of breath		Coronary artery disease		None		None	
DATE OF EXAMINATION		TIME OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		OFFICE OF EXAMINER	
JAN 16 1950		10:00 AM		[Signature]		Medical Examiner		Baltimore, Md.	

RECEIVED
JAN 16 1950
BALTIMORE, MD.

1 Item 9 Film G239 2-20-59 et 2100 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS NORWOOD ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EMANUEL -- LOMAX				4. DATE OF DEATH Month Day Year FEBRUARY 7 1959			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/75	
9. AGE (In years last birthday) 78 8 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM WORKER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM NATHANIEL LOMAX				14. MOTHER'S MAIDEN NAME LOUISE WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral confluent 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/2 , 19 55 , to 2/7 , 19 55 , that I last saw the deceased alive on 2/7 , 19 55 , and that death occurred at 11:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE A. D. Bonifant M.D.				PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 2/10/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant.,	
22d. LOCATION (City, town, or county) (State) Norbeck, Md.				24a. REC'D BY REGISTRAR DATE FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Bowden				ADDRESS Rockville, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02075

2101

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b - - - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7306 Delfield Street		d. STREET ADDRESS 7306 Delfield Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last AIMEE EUGENIE LYFORD		4. DATE OF DEATH Month Day Year Feb. 3, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1875
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min. 3 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher-Ret.		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	
11. BIRTHPLACE (State or foreign country) Rock Island, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert E. Lyford		14. MOTHER'S MAIDEN NAME Clara Burgh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Harry B. Lyford - as above #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Cerebral Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April, 1954 to Feb. 3, 1959 , that I last saw the deceased alive on Feb. 3, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles E. Woodson		ADDRESS (Street, city or town, state) DATE SIGNED 1801 Eye St. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) Charles E. Woodson, 1801 Eye St., N. W., Washington 6, D. C.			
22a. CREMATION, BURIAL, or REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-59	
22c. NAME OF CEMETERY OR CREMATORY Chippiannock Cem.		22d. LOCATION (City, town, or county) (State) Rock Island, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR DATE FEB 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2102

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 34 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Newark c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67X-3 d. STREET ADDRESS 407 18th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frederick First Middle Last MARESCH			4. DATE OF DEATH Month Day Year February 17 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-03	9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Department		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) New Jersey			
13. FATHER'S NAME Frederick MARESCH			14. MOTHER'S MAIDEN NAME Louise VALENTINE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium 204.1 MIOM and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pericarditis MIOM (c) Secondary to Leukemia, myelogenous, acute					INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 days 10 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I attended the deceased from January 14, 1959 , to February 17, 1959 , that I last saw the deceased alive on February 17, 1959 , and that death occurred at 9:50A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 2-17-59							
ACTUAL SIGNATURE J. T. Horgan		PHYSICIAN'S NAME (Type) J. T. HORGAN LCDR MC USN Bethesda, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-59		22c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery			
22d. LOCATION (City, town, or county) Newark		22e. LOCATION (City, town, or county) New Jersey		22f. LOCATION (City, town, or county) New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey Funeral Home, Bethesda, Md.			24a. REC'D BY REGISTRAR DATE FEB 19 '59				
24b. REGISTRAR'S SIGNATURE C. L. S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G239 3-2-59 et

2103

CERTIFICATE OF DEATH

Reg. Dist. No.

02078

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - 5001 Danbury Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>FRANK</u> Last <u>MARIANI</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 8, 1903</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAPPING, ITALY</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK MARIANI</u>		14. MOTHER'S MAIDEN NAME <u>MARIA SIMEONE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>THEODORE F. MARIANI - 5001 DANBURY CT.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral shock</u> <u>1550</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastro intestinal Hemorrhage</u> (c) <u>Primary carcinoma of liver</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>2 days</u> <u>8 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>February</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>59</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u>		DATE SIGNED <u>Feb 19, 59</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN M.D.</u>		ADDRESS (Street, city or town, state) <u>8641 Colverville Road Silver Spring Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NAT. MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH - VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u>		ADDRESS <u>3831 GA. AVENUE</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanlon</u>	

CERTIFICATE OF DEATH

2103

DATE OF DEATH 11/15/1919		PLACE OF DEATH Baltimore	
DECEASED Victor		FATHER Frank	
MOTHER White		AGE 32	
OCCUPATION Carpenter		EDUCATION High School	
MARITAL STATUS Married		RELIGION Roman Catholic	
CAUSE OF DEATH Tuberculosis of lungs		PERIOD OF ILLNESS 3 months	
PLACE OF BIRTH Maryland		DATE OF BIRTH Sept 8, 1887	
SEX Male		RACE White	
TENDENCY TO DISEASE None		PREVIOUS ILLNESS None	
SIGNATURE OF PHYSICIAN J. H. F. Fatterson		SIGNATURE OF DECEASED Victor	
SIGNATURE OF WITNESSES J. H. F. Fatterson, J. H. F. Fatterson		SIGNATURE OF DECEASED Victor	
DATE Nov 15, 1919		PLACE Baltimore	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1997

CERTIFICATE OF DEATH

Reg. Dist. No.

02079

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>				d. STREET ADDRESS <i>12018 Georgia Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Roland Miskel Marks</i>				4. DATE OF DEATH Month Day Year <i>2 7 1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-19-1900</i>	
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher-Safeway Stores</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>			
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Samuel D. Marks</i>				14. MOTHER'S MAIDEN NAME <i>Myrtle Marks</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT Address <i>wife - Mrs Beatrice R Marks - Same.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Myocardial Infarction</i> (c) <i>Atherosclerotic heart disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>5 1/2 - 6 hrs</i> <i>undetermined</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>2/7</i> , 19 <i>59</i> , to <i>2/7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2/7</i> , 19 <i>59</i> , and that death occurred at <i>9:50 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Marvin L. Kolkin</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>8485 Fenton Street, S.S., Md.</i>			
PHYSICIAN'S NAME (Type) <i>Marvin L. Kolkin</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 10, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Welcome Grove Baptist Church Cemetery, Warsaw, Virginia</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey Inc., Silver Spring, Md.</i> <i>Raymond A. Jicks</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE	
JAMES H. HARRIS		45		M		W		1875		BALTIMORE		BALTIMORE		BALTIMORE		MARRIED		1900		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH	
JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		NATURAL		JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH	
JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920		BALTIMORE		BALTIMORE		BALTIMORE		JAN 10 1920	



THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO KEEP THIS RECORD AND TO FURNISH COPIES OF THE SAME TO ANY PERSON WHO MAY BE INTERESTED THEREIN. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

1998

CERTIFICATE OF DEATH

Reg. Dist. No.

02080

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>47x-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>431 Randolph St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Allen Johnson Marsh</u>				4. DATE OF DEATH <u>Feb. 15 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-87</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mathen Marsh</u>				14. MOTHER'S MAIDEN NAME <u>Lida Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x</u> DUE TO <u>Wernicke's terminal coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerular nephritis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>59</u> , to <u>2/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>59</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7105 Raggs Rd. Hyattsville, Md.</u> DATE SIGNED <u>2/15/59</u>							
ACTUAL SIGNATURE <u>Hugh W. Ireys</u>				M.D. <u>7105 Raggs Rd. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Hugh W. Ireys</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hines Co.</u> ADDRESS <u>2901 14th NW</u>				24a. REC'D BY REGISTRAR <u>Feb 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME LAST, FIRST, MIDDLE (Print or write full name)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
DATE OF DEATH (Month, day, year)		PLACE OF DEATH (City, State, Country)	
TIME OF DEATH (Hour, minute)		CAUSE OF DEATH (List all causes, beginning with immediate cause)	
MANNER OF DEATH Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/>		MEDICAL HISTORY (List all diseases, injuries, operations, etc.)	
OCCASION OF DEATH (List all circumstances leading to death)		SIGNATURE OF DECEASED (If known)	
SIGNATURE OF WITNESSES (List all persons present at death)		SIGNATURE OF PHYSICIAN (If known)	
SIGNATURE OF CORONER (If known)		SIGNATURE OF JURY (If known)	
SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF CLERK (If known)	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased, or by the registrar if the death is reported as natural and the cause of death is known. It is to be filed in the office of the registrar of deaths, who will issue a death certificate to the family of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02081

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8530 Second Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>McLeod</i> Last <i>Martin</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 18, 1900</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>13</i>	11. IF UNDER 24 HRS. Hours <i>13</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Depot Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Depot Clerk</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles L. Martin</i>		14. MOTHER'S MAIDEN NAME <i>Sathe Graves</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>YES</i>	
17. INFORMANT <i>Miss Barbara Martin (daughter)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>with myocardial infarction</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>a. 1.</i> Month <i>19</i> Day <i>19</i> Year <i>1959</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 18, 1956</i> , to <i>Feb 13, 1959</i> , that I last saw the deceased alive on <i>Sept 22, 1958</i> , and that death occurred at <i>8</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>918 Ellsworth Drive Silver Spring Md 2-13-59</i>	
PHYSICIAN'S NAME (Type) <i>PHILIP E. JONES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2/16/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>OAK HILL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>Raymond H. Baska</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital			d. STREET ADDRESS 4306 Leland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Tudor Matson			4. DATE OF DEATH Month Day Year February 2, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1900		9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Info. Ag.		11. BIRTHPLACE (State or foreign country) Kansas City, Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Matthew Lawrence Matson			14. MOTHER'S MAIDEN NAME Bessie Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 443-24-5843		17. INFORMANT Address G ladys Gay Matson (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 576 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status postoperative DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Early generalized peritonitis					INTERVAL BETWEEN ONSET AND DEATH immediate immediate
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2-3-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/5/59	22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9 days

Bethesda

Suburban

Matson

Tudor

Lawrence

X

May 25, 1900

White

Male

Civil Engineer

Kansas City

Bessie

Matthew Lawrence Matson

Yes

No

Gladys Gay Matson

X

X

1999 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 FilmG239 2-27-59 et
CERTIFICATE OF DEATH

Reg. Dist. No.

02082

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>69th St</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York, Zone 58</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>				d. STREET ADDRESS <u>2565 Marion Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sara Crandall Maxwell</u>				4. DATE OF DEATH Month Day Year <u>February 21, 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. Children's Wear Clothing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Bernard Maxwell</u>				14. MOTHER'S MARDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>110-12-6568</u>		17. INFORMANT <u>Roland P. Amateis</u> Address <u>3700 Mass. Ave. N.W. Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Congestive Heart Failure, due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO <u>And</u> (c) <u>Broncho-pneumonia</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Weeks</u> <u>Years</u> <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 9th, 1959</u> , to <u>Feb. 21, 1959</u> , that I last saw the deceased alive on <u>Feb. 20, 1959</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace H. Mook</u>				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave. Tak. Pk., Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wallace H. Mook</u>				DATE SIGNED <u>2/21/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cem.,</u>		22d. LOCATION (City, town, or county) (State) <u>Westchester Co., New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2106

CERTIFICATE OF DEATH

Reg. Dist. No.

02083

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>4 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9612 Cedar Lane, Bethesda</u>				d. STREET ADDRESS <u>19612 Cedar Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Ann McMahon</u>				4. DATE OF DEATH Month Day Year <u>February 7 1959</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 26, 1883</u>		
9. AGE (In years last birthday) <u>75</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>								
13. FATHER'S NAME <u>William McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Mary Langan</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lewis Thomas - 9612 Cedar Lane, Beth.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with generalized metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Coronary Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <u>Washington, D.C.</u>				20g. (County)		20h. (State)		
21. I certify that I attended the deceased from <u>November</u> , 19 <u>58</u> , to <u>Feb 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>February 6</u> , 19 <u>59</u> , and that death occurred at <u>7⁰⁰ A.M.</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>James W. Egan</u>				ADDRESS (Street, city or town, state) <u>M.D. 7720 Wisconsin Ave., Bethesda, Md.</u>				
PHYSICIAN'S NAME (Type) <u>James W. Egan</u>				DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 FilmG239 3-6-59 et

Reg. Dist. No.

A-20-59
12084

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Linthicum 02X-2</u> d. STREET ADDRESS <u>327 Maple Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Milfred</u> Middle <u>Meadows</u> Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-17-21</u> 9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Excavating + Grading (Self Emp)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Waynesborough, Pa.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month Day Year <u>February 26, 1959</u>	
13. FATHER'S NAME <u>Elmer F. Meadows</u>		14. MOTHER'S MAIDEN NAME <u>Edna Woods</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>yes</u> <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>(160 163739)</u>	
17. INFORMANT <u>Mrs. Marvin Meadows</u> Address <u>Glen Burnie, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures (two) of vertebral column with spinal cord compression, multiple rib fractures, skull fracture</u> DUE TO <u>Trauma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>910.8</u> (c) <u>910.8</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Midshaft fracture of right femur and left hemothorax</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Man struck in back by stump which fell from truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:00</u> p.m. <u>2-24</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>vacant lot</u> 20f. (City or town) (County) (State) <u>Silver Spring Monty Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		24a. REC'D BY REGISTRAR <u>W. H. 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>William H. 2 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

FOR STATE
HEALTH DEPT.

2107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>11503 Higby St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11503 Higby St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lewis</u>	4. DATE OF DEATH <u>Feb 8 1959</u>	5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7-8-98</u>	9. AGE (In years last birthday) <u>60</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>APPLIANCE REPAIRMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>ROBERT T. MEWS</u>		14. MOTHER'S MAIDEN NAME <u>JANE EXELBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-38-0636</u>	
17. INFORMANT <u>Mrs. Ethel M. Best, 1349 Dewey Ave.</u>		Address <u>Rochester, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>002X</u> DUE TO <u>Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). <u>Acute Alcoholism</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BALTIMORE

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		DIAGNOSIS		TREATMENT		HISTORY		FAMILY HISTORY	
SIGNED AND SWORN TO before me this _____ day of _____, 19____		ATTEST		NOTARY PUBLIC		JURY		CORONER	
MEDICAL EXAMINER		JURY		CORONER		SIGNED AND SWORN TO before me this _____ day of _____, 19____		ATTEST	
NOTARY PUBLIC		JURY		CORONER		SIGNED AND SWORN TO before me this _____ day of _____, 19____		ATTEST	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2108

CERTIFICATE OF DEATH

02086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7925 Chicago Avenue				d. STREET ADDRESS 7925 Chicago Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JACOB WILLIAM MEYERS				4. DATE OF DEATH Month Day Year February 18 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1876		9. AGE (In years lost birthday) yrs. 82	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant - Retired				10b. KIND OF BUSINESS OR INDUSTRY Poland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Bernard Meyers				14. MOTHER'S MAIDEN NAME Anna Litke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Jennie Meyers 7925 Chicago Ave., S.S. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic obstruction (benign) + chemoprophylaxis DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2-3 months 45 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8641 Colesville Rd., Silver Spring, Md.	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1958 , to Feb 18 1959 , that I last saw the deceased alive on Feb 17 1959 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Blaine Fig.				M.D. 8641 Colesville Rd., Silver Spring, Md. Feb 18 1959			
PHYSICIAN'S NAME (Type) Blaine Fig. M.D.				ADDRESS (Street, city or town, state) 8641 Colesville Rd., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20, 1959		22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons				ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR FEB 24 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2109

CERTIFICATE OF DEATH

Reg. Dist. No.

02087

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>478-3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <u>4652 Wisconsin Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Frances Mills</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-2-77</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>James B. Lovett</u>				14. MOTHER'S MARDEN NAME <u>Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>_____</u>			
17. INFORMANT <u>Bertha Brown</u> Address <u>419 Univ. Blvd. E. Silver Spring Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIOLE PNEUMONIA</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PLEURAL EFFUSION.</u> DUE TO (c) <u>PULMONARY EMBOLISM.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis Sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 20, 1959</u> , to <u>Feb 7, 1959</u> , that I last saw the deceased alive on <u>2-7-59</u> , 19 <u>59</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.P. Andrews</u>				ADDRESS (Street, city or town, state) <u>4201 FESSENDEN ST. N.W.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS M.D.</u>				<u>WASHINGTON D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hamilton Va</u>		22d. LOCATION (City, town, or county) (State) <u>Hamilton Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adams Funeral Home</u> ADDRESS <u>474 E. Wisconsin</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2189

MD. 10-10-18

1. NAME OF DECEASED MRS. J. M. HARRIS		2. SEX F		3. AGE 68		4. DATE OF BIRTH 1850		5. PLACE OF BIRTH BALTIMORE, MD.	
6. OCCUPATION HOUSEWIFE		7. MARITAL STATUS WIDOW		8. COLOR WHITE		9. RELIGION METHODIST		10. EDUCATION HIGH SCHOOL	
11. DECEASED AT HOME		12. PLACE OF DEATH BALTIMORE, MD.		13. DATE OF DEATH JAN 10 1918		14. TIME OF DEATH 10:30 AM		15. CAUSE OF DEATH HEMIPLEGIC STROKE	
16. DISEASE OR INJURY HEMIPLEGIC STROKE		17. PERIOD OF ILLNESS 2 WEEKS		18. PRESENT ILLNESS HEMIPLEGIC STROKE		19. PREVIOUS ILLNESS NONE		20. PRESENT TREATMENT NONE	
21. SIGNATURE OF PHYSICIAN J. M. HARRIS		22. SIGNATURE OF DECEASED J. M. HARRIS		23. SIGNATURE OF WITNESS J. M. HARRIS		24. SIGNATURE OF DECEASED J. M. HARRIS		25. SIGNATURE OF WITNESS J. M. HARRIS	

FILED IN 10-10-18

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2015

CERTIFICATE OF DEATH

Reg. Dist. No.

02088

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 419 Park Road		d. STREET ADDRESS 419 Park Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT W. MILLS		4. DATE OF DEATH February 24, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR 3 Months 27 Days 27 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Mills		14. MOTHER'S MAIDEN NAME Margaret V. Butt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Sadie Johnson-sister-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction DUE TO (b) Coronary Thrombosis DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 12 hrs Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old CVA.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1953 , to 2/24/1959 , that I last saw the deceased alive on 2/24/1959 , and that death occurred at 9:16 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen W. Jones		DATE SIGNED 2/24/59	
PHYSICIAN'S NAME (Type) Stephen Jones		ADDRESS (Street, city or town, state) Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/59	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2012

RECEIVED

Montgomery

Maryland

Montgomery

Rockville

Rockville

410 Park Road

410 Park Road

W. M. L.

ROBERT

Male

White

John

John

Stephen Jones - Rockville, Maryland

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2110 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2</u> hour		d. STREET ADDRESS <u>4427 Bradley Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E.</u> Last <u>Milton</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carriers Drug Store Minnesota</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred M il ton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anna M ossburger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife - Marcha L. Milton - Same as 2</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

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AP

DEPT. OF HEALTH
DIVISION OF VITAL RECORDS

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
RACE: [illegible] BIRTH DATE: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIED: [illegible] SPOUSE: [illegible]
RELIGION: [illegible]
MILITARY SERVICE: [illegible]
PREVIOUS ILLNESS: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
TIME OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE OF EXAMINATION: [illegible]

2-18-99
J. H. [illegible]
Birmingham, Ala.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 7, 8 Film G239 2-20-59 et

2111

CERTIFICATE OF DEATH

Reg. Dist. No.

02090

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. C. land b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 25 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 1508 44th. St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ona Middle S. Last Moise		4. DATE OF DEATH Month Feb. Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/86 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Georgia
13. FATHER'S NAME J.H. Spilm an		14. MOTHER'S MAIDEN NAME Margaret Bisinem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.4 Metastatic Melanoma of Dorsal Spine DUE TO with paraplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Malignant Melanoma of scalp DUE TO 5 yrs (c) 1) Cord paralysis of urinary bladder		INTERVAL BETWEEN ONSET AND DEATH one month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Cord paralysis of urinary bladder		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, 19 Day, 19 Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to Feb 15 1959 , that I last saw the deceased alive on Feb 15 1959 , and that death occurred at 235 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp M.D.		ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 DC DATE SIGNED Feb 15 '59	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/18/59	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT.	22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Bische		24a. REC'D BY REGISTRAR 3034 M St NW	
24b. REGISTRAR'S SIGNATURE DR.		DATE FEB 17 '59	

CERTIFICATE OF DEATH

2111

NAME OF DECEASED MARY ANN		SEX F		RACE W		DATE OF BIRTH 10-10-1885		PLACE OF BIRTH BALTIMORE, MD	
MARITAL STATUS MARRIED		OCCUPATION CLERK		CAUSE OF DEATH DISEASE		PERIOD OF ILLNESS 10-15-1911		PLACE OF DEATH BALTIMORE, MD	
NAME OF PHYSICIAN DR. J. H. BROWN		NAME OF FUNERAL HOME J. H. BROWN		NAME OF BURIAL PLACE GREENWICH CEMETERY		DATE OF BURIAL 10-20-1911		NAME OF MINISTER REV. J. H. BROWN	
NAME OF NEXT OF KIN J. H. BROWN		NAME OF WITNESS J. H. BROWN		NAME OF REGISTRAR J. H. BROWN		NAME OF CLERK J. H. BROWN		NAME OF ASSISTANT CLERK J. H. BROWN	
NAME OF DECEASED MARY ANN		SEX F		RACE W		DATE OF BIRTH 10-10-1885		PLACE OF BIRTH BALTIMORE, MD	
MARITAL STATUS MARRIED		OCCUPATION CLERK		CAUSE OF DEATH DISEASE		PERIOD OF ILLNESS 10-15-1911		PLACE OF DEATH BALTIMORE, MD	
NAME OF PHYSICIAN DR. J. H. BROWN		NAME OF FUNERAL HOME J. H. BROWN		NAME OF BURIAL PLACE GREENWICH CEMETERY		DATE OF BURIAL 10-20-1911		NAME OF MINISTER REV. J. H. BROWN	
NAME OF NEXT OF KIN J. H. BROWN		NAME OF WITNESS J. H. BROWN		NAME OF REGISTRAR J. H. BROWN		NAME OF CLERK J. H. BROWN		NAME OF ASSISTANT CLERK J. H. BROWN	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

2001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>9-3-59 11:30 am</u> <u>2-4-59 12:35 am</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & Hospital</u>				1d. STREET ADDRESS <u>4714 Franklin St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Phoebe</u> Middle <u>ANN</u> Last <u>NIOTE</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>4</u> Year <u>1959</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-19</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Jack S. Ammons</u>				14. MOTHER'S MAIDEN NAME <u>Bertie Lerles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>		Address <u>Record Office</u> <u>Washington SAN & Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left cerebral hemorrhage with 330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>massive subdural hematoma</u> DUE TO (c) <u>probably due to ruptured aneurysm</u> several days.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2</u> , 19 <u>59</u> , to <u>Feb 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 3</u> , 19 <u>59</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.				<u>2/4/59</u>			
PHYSICIAN'S NAME (Type) <u>Bennett A. Porter, Jr.</u> <u>9301 Colesville Rd. Silver Spring, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Bur-Transit</u>		<u>2/7/59</u>		<u>Mt. Hope Cemetery</u>		<u>Florence, S. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

CERTIFICATE OF DEATH

7001

REG. CH. 104

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. DATE OF BIRTH [REDACTED]</p>		<p>4. PLACE OF BIRTH [REDACTED]</p>	
<p>5. OCCUPATION [REDACTED]</p>		<p>6. MARITAL STATUS [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>	
<p>9. TIME OF DEATH [REDACTED]</p>		<p>10. PLACE OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>17. SIGNATURE OF DECEASED [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>21. SIGNATURE OF DECEASED [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>23. SIGNATURE OF DECEASED [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>27. SIGNATURE OF DECEASED [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>29. SIGNATURE OF DECEASED [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>33. SIGNATURE OF DECEASED [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>35. SIGNATURE OF DECEASED [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>39. SIGNATURE OF DECEASED [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>41. SIGNATURE OF DECEASED [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>45. SIGNATURE OF DECEASED [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>47. SIGNATURE OF DECEASED [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>51. SIGNATURE OF DECEASED [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>53. SIGNATURE OF DECEASED [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>57. SIGNATURE OF DECEASED [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>59. SIGNATURE OF DECEASED [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>61. SIGNATURE OF DECEASED [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>63. SIGNATURE OF DECEASED [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>65. SIGNATURE OF DECEASED [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>69. SIGNATURE OF DECEASED [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>71. SIGNATURE OF DECEASED [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>75. SIGNATURE OF DECEASED [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>77. SIGNATURE OF DECEASED [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>81. SIGNATURE OF DECEASED [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>83. SIGNATURE OF DECEASED [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>85. SIGNATURE OF DECEASED [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>87. SIGNATURE OF DECEASED [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>89. SIGNATURE OF DECEASED [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>93. SIGNATURE OF DECEASED [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>95. SIGNATURE OF DECEASED [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>99. SIGNATURE OF DECEASED [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS [REDACTED]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02092

2112

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 14 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 7701 Georgia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Estell Last MUDD		4. DATE OF DEATH Month February Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-82
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles LOMBARDY		14. MOTHER'S MAIDEN NAME Rose HAMMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT (Son) Joseph F. MUDD		Address 225 Grant Ave. Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1 , 19 59 , to February 8 , 19 59 , that I last saw the deceased alive on February 8 , 19 59 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bethesda 14 Maryland 2-8-59			
ACTUAL SIGNATURE A. Miale Jr.		M.D. U.S. Naval Hospital NMMC	
PHYSICIAN'S NAME (Type) A. MIALE Jr. LTMC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-11-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington VA.
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey		ADDRESS 8434 Georgia Ave. N.W. WASH. D.C.	
24a. REC'D BY REGISTRAR Warner E Pumphrey Inc. S.S.MD		24b. REGISTRAR'S SIGNATURE Arthur E. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

COLOR

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

PREVAILING WEATHER

PREVAILING WIND

PREVAILING HUMIDITY

PREVAILING PRESSURE

PREVAILING TEMPERATURE

PREVAILING MOON

PREVAILING STARS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2113

CERTIFICATE OF DEATH

Reg. Dist. No.

02093

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 56 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8320 16th Street		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 18320 16th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arthur Reuben Myers, Sr.		4. DATE OF DEATH February 25, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/95
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Portsmouth, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Calvin Baysue Myers		14. MOTHER'S MAIDEN NAME Eleanor Essex	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Distention 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 weeks 8 years Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1950 , to Feb. 25, 1959 , that I last saw the deceased alive on Feb. 25, 1959 , and that death occurred at 6:27 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Wardrop, M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) W.B. WARDROP MD 837 BONIFANT ST SILVER SPRING MD		DATE SIGNED Feb 25 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 2/28/59	
22c. NAME OF CEMETERY OR CREMATORY West View Cemetery		22d. LOCATION (City, town, or county) (State) Atlanta, Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. News Co. 2901 K St. N.W. D.C.		24a. REC'D BY REGISTRAR Arthur S. Kraus	
24b. REGISTRAR'S SIGNATURE		DATE FEB 27 '59	

2114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 705 RITCHIE AVENUE				e. STREET ADDRESS 705 RITCHIE AVENUE			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. A. Last NAECKER				4. DATE OF DEATH Month FEB. Day 3 Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/28/74		9. AGE (In years lost birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIANO TUNER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST NAECKER				14. MOTHER'S MAIDEN NAME KATHERINE BOETTCHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs, John G. Lorz, 705 Ritchie Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stasis Bronchopneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema DUE TO (c) Hypertensive Cardiovascular disease est. 10 yrs							INTERVAL BETWEEN ONSET AND DEATH 2 days 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abscess Parotid gland rt							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from Aug , 19 54 , to Feb , 19 59 , that I last saw the deceased alive on Feb 3 , 19 59 , and that death occurred at 10:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph E. Patten M.D.				ADDRESS (Street, city or town, state) 8641 Colverville Road Silver Spring Md			
PHYSICIAN'S NAME (Type) RALPH E. PATTEN M.D.				DATE SIGNED 2/3/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

2115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 4 days				d. STREET ADDRESS 1624 Kenilworth Avenue, N. E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Allean Middle Lorraine Last Neal		4. DATE OF DEATH		Month February Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1925		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Assistant		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Crawford				14. MOTHER'S MAIDEN NAME Ada Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 241-32-2580		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis and Pericarditis DUE TO (c) Lupus Erythematosus							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 21, 19 59 , to February 25, 19 59 , that I last saw the deceased alive on February 25, 19 59 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2/26/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Eugene B. Feigelson		M.D. EUGENE B. FEIGELSON, M.D.					
PHYSICIAN'S NAME (Type) EUGENE B. FEIGELSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-27-59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Wilson, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE A. N. Horton ADDRESS 1322 York St N.W.				24c. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

Address of Baltimore

Residence of Baltimore

Place of Baltimore

Occupation of Baltimore

Marital Status of Baltimore

Age of Baltimore

Sex of Baltimore

Date of Birth of Baltimore

Date of Death of Baltimore

Time of Death of Baltimore

Place of Death of Baltimore

Signature of Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2116

CERTIFICATE OF DEATH

Reg. Dist. No.

02095

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 22 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OLD BALTIMORE ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				4. DATE OF DEATH Month FEB. Day 19 Year 1959			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle ELIZABETH Last NICHOLSON				5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9/6/09				9. AGE (In years lost birthday) 49 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY CO-OP MARKETS			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS E. SHAW				14. MOTHER'S MAIDEN NAME EDNA G. BAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-34-3403			
17. INFORMANT Mr. Robert G. Nicholson, Old Baltimore Rd. Olney, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction acute DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from AUG. 18, 1953 to 19 FEB. 1959 , that I last saw the deceased alive on 10 Feb. 1959 , and that death occurred at 6:05 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Ziegler M.D. ADDRESS (Street, city or town, state) Olney, Md DATE SIGNED 19 Feb 59							
PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 2/22/59							
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY							
22d. LOCATION (City, town, or county) (State) OLNEY, MONTGOMERY COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.							
24a. REC'D BY REGISTRAR DATE FEB 24 '59							
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02096

2117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1212 Rupert Road		d. STREET ADDRESS 1212 Rupert Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK ROBERT NICKOLSON		4. DATE OF DEATH Month Feb. Day 26, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1874
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 11 Days 16	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-Foreman-Retired		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME ? Nickolson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Wife		Address Same as Item #2	
17. NAME OF INFORMANT Inez Osmand Nickolson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		INTERVAL BETWEEN ONSET AND DEATH 6 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 17, 1959 to Feb 26, 1959 , that I lost sows the deceased olive on Feb 26, 1959 , and that death occurred at 8:30 PM , from the causes and on the date stated above.		DATE SIGNED 2-27-59	
ACTUAL SIGNATURE John N. Andrews M.D.		ADDRESS (Street, city or town, state) 9601 Colesville Rd., Silver Spring, Maryland	
PHYSICIAN'S NAME (Type) JOHN N. ANDREWS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-2-59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOT FOR STATE DEPARTMENT OF HEALTH - BIRMINGHAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG239 2-24-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02057

2118

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A. Middle John Last NIELSEN		4. DATE OF DEATH Month February Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1877
9. AGE (In years last birthday) 80 81 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Christian Nielsen		14. MOTHER'S MAIDEN NAME ? Andersen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Martha Ford-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 12 hours 2+ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 29 Jan, 1959 , to 13 Jan, 1959 , that I last saw the deceased alive on 12 Jan, 1959 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert Martyn Jr.		M.D. 5029 BETHESDA AVE.	
PHYSICIAN'S NAME (Type) HERBERT MARTYN JR.		BETH. Md. 14 Jan 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/16/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR FEB 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2119
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 hrs. 42 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Arlington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1500 Arlington Blvd.		4. DATE OF DEATH Month February		Day 15		Year 1959	
3. NAME OF DECEASED (Type or print) James		First James		Middle NIELSEN		Last NIELSEN		5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66		11. IF UNDER 24 HRS. Days 66		12. Hours 66	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		14. KIND OF BUSINESS OR INDUSTRY U.S. Navy		15. BIRTHPLACE (State or foreign country) Denmark		16. CITIZEN OF WHAT COUNTRY? U.S.A.		17. FATHER'S NAME Niels Peter NIELSEN		18. MOTHER'S MAIDEN NAME Margaret SKOV	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		20. (If yes, give war or dates of service) WWI & WWII		21. SOCIAL SECURITY NO. 577-38-0216		22. INFORMANT Hospital Records		23. Address Hospital Records		24. Address Hospital Records	
25. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paroxysmal Cardiac Arrhythmia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		26. INTERVAL BETWEEN ONSET AND DEATH Immediate 5 years		27. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extensive myocardial Infarction July 1958		28. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Maryland		(State) Maryland	
21. I certify that I attended the deceased from February 15, 1959 , to February 15, 1959 , that I last saw the deceased alive on February 15, 1959 , and that death occurred at 7:57A.M. from the causes and on the date stated above.											
22. ACTUAL SIGNATURE F. S. Caldwell		23. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC		24. DATE SIGNED 2-16-59		25. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		26. ADDRESS Bethesda 14, Maryland		27. ADDRESS Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA		(State) VIRGINIA		23. FUNERAL DIRECTOR'S SIGNATURE M. F. Wade	
24. ADDRESS 57 W.W. Chambers Co.		24a. REC'D BY REGISTRAR FEB 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline		24c. ADDRESS 57 W.W. Chambers Co.		24d. ADDRESS 57 W.W. Chambers Co.		24e. ADDRESS 57 W.W. Chambers Co.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

21 19

STATE OF MARYLAND

CITY OF BALTIMORE

COUNTY OF BALTIMORE

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DECEASED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2120

CERTIFICATE OF DEATH

Reg. Dist. No.

02099

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Layhill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seymour Nursing Home		d. STREET ADDRESS 2032 Belmont St. N.W.	
3. NAME OF DECEASED (Type or print) First Helen D. Middle Norfleet Last		4. DATE OF DEATH Feb. 9, 1959 Day 9 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/80
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk Treasury Dept.		10b. KIND OF BUSINESS OR INDUSTRY Binghamton, N.Y.	
11. BIRTHPLACE (State or foreign country) Binghamton, N.Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME P. Donald Driscoll		14. MOTHER'S MAIDEN NAME Anna Louise Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Hadwen Hiller		Address 100 Myrtle St. Manchester, N.H.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - 446X DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephritis, Chronic - DUE TO Arterio-sclerosis (c) Arterio-sclerosis INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 545			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14/48 , 19____, to 2/9/58 , 19____, that I last saw the deceased alive on 2/8/59 , 19____, and that death occurred at 7:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James A. O'Keefe M.D. 450 Conn. Ave. N.W. Wash. D.C. PHYSICIAN'S NAME (Type) James A. O'Keefe MD			
22a. BURIAL, CREMATION, or other disposal (Specify) burial		22b. DATE THEREOF 2/13/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24c. DATE FEB 12 1959	

CERTIFICATE OF DEATH

1125

1125

1125

1125

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD		USA		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1905		BALTIMORE		MD		USA		BALTIMORE		MD		USA		USA	
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
LABORER		1905		BALTIMORE		MD		USA		BALTIMORE		MD		USA		USA	
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
HEART DISEASE		1925		BALTIMORE		MD		USA		BALTIMORE		MD		USA		USA	
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
NATURAL		1925		BALTIMORE		MD		USA		BALTIMORE		MD		USA		USA	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
J. H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		MD		USA		USA	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
J. H. HARRIS		1925		BALTIMORE		MD		USA		BALTIMORE		MD		USA		USA	

2002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>3622 Park Heights</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel (NMN) Nov</u>				4. DATE OF DEATH Month Day Year <u>Feb. 2 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-19-87</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>Hyman Cohen</u>				14. MOTHER'S MAIDEN NAME <u>Hannah - (unknown to pt)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Pt's Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1-2-3-59 to 1-26-59 4 years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-26</u> , 19 <u>59</u> , to <u>2-2-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-3-</u> , 19 <u>59</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md</u>		DATE SIGNED <u>2/5/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goddard Funeral Home</u> ADDRESS <u>4217-9th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2002

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		39		12-1-42		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. RACE		18. COLOR		19. HEIGHT		20. WEIGHT		21. BUILD		22. COMPLEXION		23. HAIR		24. EYES	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5'10"		170		SLIM		FAIR		BROWN		BLUE	
25. PREVIOUS ILLNESS		26. PREVIOUS SURGERY		27. PREVIOUS TRAUMA		28. PREVIOUS DRUGS		29. PREVIOUS ALCOHOL		30. PREVIOUS TOBACCO		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS		46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE REGISTRAR OF DEATHS. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS TO BE MAINTAINED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS TO BE MAINTAINED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

2121
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>1528 Lincoln St</u>	
3. NAME OF DECEASED (Type or print) <u>AAVE Infant</u>		4. DATE OF DEATH <u>FEB 12 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 11 1959</u>
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Edwin Nuckols</u>		14. MOTHER'S MAIDEN NAME <u>MARY INEZ SPONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William E. Nuckols, Jr. - same as 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Helicobacter, bilateral</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brematurity</u> (c) <u>prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 11</u> , 19 <u>59</u> , to <u>Feb. 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 12</u> , 19 <u>59</u> , and that death occurred at <u>10:05 M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Philip H. Varner</u>		M.D. <u>12, 620 Ga. Ave., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip H. Varner</u>		<u>10620 Ga. Ave. Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D. BY REGISTRAR <u>FEB 18 59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

207-223 XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2122

CERTIFICATE OF DEATH

Reg. Dist. No.

02101

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY in 1b 9 yrs 4½ mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester 06 x - 2	
3. NAME OF DECEASED (Type or print) Iydia First Middle Last OURSLEA		4. DATE OF DEATH Month Feb Day 24 Year 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kept house		11. BIRTHPLACE (State or foreign country) Manchester, Md.	
13. FATHER'S NAME Edward Oursler		14. MOTHER'S MAIDEN NAME Juilann Weaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of rectum & metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6-12-57
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC 12 , 19 55 , to FEB 24 , 19 59 , that I last saw the deceased alive on FEB 23 , 19 59 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 CEDAR LANE KENSINGTON, MD	
PHYSICIAN'S NAME (Type) Sarah E. Glover		DATE SIGNED 2-24-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-26-59	22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	22d. LOCATION (City, town, or county) (State) Manchester Md
23. FUNERAL DIRECTOR'S SIGNATURE Frederick C. Gertner, Gaithersburg Md		24. REC'D BY REGISTRAR DATE FEB 26 59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
ATTORNEY		HEART DISEASE		NATURAL		AT HOME		JAN 6 1968	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		TIME		PLACE		CITY		STATE	
JAN 6 1968		10:00 AM		AT HOME		BALTIMORE		MD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2123

CERTIFICATE OF DEATH

Reg. Dist. No.

02102

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville (Rural)				c. LENGTH OF STAY IN 1b 14yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle OWENS Last OWENS				4. DATE OF DEATH Month Feb. Day 23 Year 19 59			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Nelson				14. MOTHER'S MAIDEN NAME Irene Nelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Solomon Owens Address Poolesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from OCT. 1958 , to FEB. 23, 1959 , that I last saw the deceased alive on FEB. 21, 1959 , and that death occurred at 4:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Vernon E. Martens M.D.				ADDRESS (Street, city or town, state) Hermanston, Ind. 2-23-59			
DATE SIGNED Feb. 23, 1959				DATE SIGNED Feb. 23, 1959			
PHYSICIAN'S NAME (Type) Dr. Vernon E. Martens.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/59		22c. NAME OF CEMETERY OR CREMATORY Elijah,		22d. LOCATION (City, town, or county) (State) Poolesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swindle ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

hypertension
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submitting yk

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11. 11. 1944

Amundsen 31.10.1911

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville (rural)</u>	
c. LENGTH OF STAY IN 1b <u>11 yrs</u>		d. STREET ADDRESS <u>10517 Seven Locks Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10517 Seven Locks Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John M. Payne</u>		4. DATE OF DEATH <u>Feb 2 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Payne</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Florence Payne (wife)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-2-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/5/59</u>	<u>Lincoln Park</u>	<u>Rockville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 9 '59</u>	
ADDRESS <u>Rockville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2018
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH
2018

DECEASED

DATE OF BIRTH
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DATE OF DEATH
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2124

CERTIFICATE OF DEATH

02104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 18 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 808 HERON DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MATHILDA MARIE PEACOCK		4. DATE OF DEATH Month FEB. Day 16 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/01
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECEPTIONIST		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL SCHAFF		14. MOTHER'S MAIDEN NAME CATHERINE YAGO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mr. Francis A. Peacock, 808 Heron Drive		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with extensive localized spread 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/8 , 19 57 , to 2/16 , 19 59 , that I last saw the deceased alive on 2/14 , 19 59 , and that death occurred at 5:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Harold F. McCann M.D. 3355-16th St. N.W. Washington D.C.			
ACTUAL SIGNATURE HAROLD F. MCCANN		PHYSICIAN'S NAME (Type) HAROLD F. MCCANN	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/18/59	
22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR FEB 18 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIAGNOSIS

TREATMENT

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

2125

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 hrs 52 min		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indianhead d. STREET ADDRESS 3 Cogswell Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jack Alen PEREZ		4. DATE OF DEATH Month Day Year February 14 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 February 1959
9. AGE (In years last birthday) yrs. Months Days 5 5 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edmund A PEREZ		14. MOTHER'S MAIDEN NAME Judith Ann YANCEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT (F) Edmund A. Perez, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Anoxia Prematurity INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 52 min		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 February 1959 , to 14 February 1959 , that I last saw the deceased alive on 14 February 1959 , and that death occurred at 2:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. A. Magnant M.D.		ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 2-14-59	
PHYSICIAN'S NAME (Type) George J. A. MAGNANT, LT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 2/16/59	
22c. NAME OF CEMETERY OR CREMATORY Valhalla		22d. LOCATION (City, town, or county) (State) Godfrey Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. D.C.		24a. REC'D BY REGISTRAR FEB 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

6



1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00758

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mass</u> b. COUNTY <u>Hampshire</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>2 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Florence</u>		<u>58 x - 3</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3301 Turner La</u>			d. STREET ADDRESS <u>62 Middle St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Grace Anna Phillips</u>			4. DATE OF DEATH <u>Feb 1 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1886</u>	9. AGE (in years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Chas Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Phebe A. Clark</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>015-26-1441</u>		17. INFORMANT <u>Wm H S. Goodwin</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>sudden</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Springfield, Mass.</u>	(County) <u></u>	(State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-1-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>2/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Springfield, Mass.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>			24a. REC'D BY REGISTRAR <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

RECEIVED
FEB 27 1968

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SECTION

1. NAME OF DECEASED: [Illegible]

2. SEX: [Illegible] AGE: [Illegible]

3. RACE: [Illegible]

4. DATE OF BIRTH: [Illegible]

5. PLACE OF BIRTH: [Illegible]

6. DATE OF DEATH: [Illegible]

7. TIME OF DEATH: [Illegible]

8. PLACE OF DEATH: [Illegible]

9. CAUSE OF DEATH: [Illegible]

10. MANNER OF DEATH: [Illegible]

11. SIGNATURE OF EXAMINER: [Illegible]

12. DATE OF SIGNATURE: [Illegible]

13. ADDRESS OF EXAMINER: [Illegible]

14. TELEPHONE NUMBER: [Illegible]

15. HOSPITAL OR CLINIC: [Illegible]

16. PHYSICIAN: [Illegible]

17. NURSE: [Illegible]

18. OTHER: [Illegible]

19. SIGNATURE OF WITNESS: [Illegible]

20. DATE OF SIGNATURE: [Illegible]

21. ADDRESS OF WITNESS: [Illegible]

22. TELEPHONE NUMBER: [Illegible]

23. HOSPITAL OR CLINIC: [Illegible]

24. PHYSICIAN: [Illegible]

25. NURSE: [Illegible]

26. OTHER: [Illegible]

2127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 12 Manchester Place			
3. NAME OF DECEASED (Type or print) First Ilona Middle (None) Last Pint				4. DATE OF DEATH Month February Day 6 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1925	
9. AGE (In years lost birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.		IF UNDER 24 HRS. Months 33 Days 33 Hours 33 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manicurist				10b. KIND OF BUSINESS OR INDUSTRY Beauty Salon		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? Hungary							
13. FATHER'S NAME Bela Szahali				14. MOTHER'S MAIDEN NAME Anna Muller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure - aspiration of vomitus DUE TO (b) Intestinal obstruction DUE TO (c) Epidermoid carcinoma of cervix uteri - Status - post total pelvic exenteration with recurrence. INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 6 Weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 5, 1959 , to February 6, 1959 , that I last saw the deceased alive on February 6, 1959 , and that death occurred at 1:00 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-6-59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Marvin M. Romsdahl, M.D.							
PHYSICIAN'S NAME (Type) Marvin M. Romsdahl, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-59		22c. NAME OF CEMETERY OR CREMATORY Wm. & Clint Co.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Jr. Inc. 1400 Chapin St. N.W.				24a. REC'D BY REGISTRAR FEB 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Farris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2128

CERTIFICATE OF DEATH

Reg. Dist. No.

02107

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1965 Rosemary Hills Drive</u>				d. STREET ADDRESS <u>1965 Rosemary Hills Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Henrietta</u> First <u>Plotnick</u> Middle Last				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Pincus Wollner</u>				14. MOTHER'S MAIDEN NAME <u>Rae Rosenfeld</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Shirley Jacobs</u> Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE (CARLIER Metastases)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>THYROID CANCER</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic disease To Lungs, Brain and Bone</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/5</u> , 19 <u>59</u> , to <u>2/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>59</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max Sherer MD</u>				ADDRESS (Street, city or town, state) <u>2025 East West Hwy Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Max Sherer</u>				DATE SIGNED <u>2/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 1959</u>		22c. NAME OF CEMETERY, OR CREMATORY <u>Wellwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Farmingdale, L.I., N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u> ADDRESS <u>Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02108

2129

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 45 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg d. STREET ADDRESS Rt. #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles (none) PRATHER				4. DATE OF DEATH Month Day Year February 13 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-18	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator				10b. KIND OF BUSINESS OR INDUSTRY NNMC, Bethesda, Md.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Howard PRATHER				14. MOTHER'S MAIDEN NAME Rosie LANCASTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 219-01-7883		17. INFORMANT Address (W) Mrs. Rosie Prather, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 INTERVAL BETWEEN ONSET AND DEATH 45 min							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 1959 , to February 13, 1959 , that I last saw the deceased alive on February 13, 1959 and that death occurred at 5:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 2-13-59							
ACTUAL SIGNATURE [Signature] M.D. U. S. Naval Hospital, NNMC							
PHYSICIAN'S NAME (Type) M. R. PLAUT, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden ADDRESS Funeral Home, Rockville, Md.				24a. REC'D BY REGISTRAR FEB 16 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2158

DECEASED

DECEASED

DECEASED

2158

2130

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 14 days			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Lee c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Myers 48x-3 ✓ d. STREET ADDRESS P.O. Box 1125 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last John Edward PRAYTOR			4. DATE OF DEATH Month Day Year February 3 19 59		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-21		9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John PRAYTOR		
14. MOTHER'S MAIDEN NAME Edna GILCHRIST			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII-KOREAN		
16. SOCIAL SECURITY NO.			17. INFORMANT Address (W) Mrs. Jeanne Praytor, same as #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glioblastoma multiforme 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 7 mos.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 20, 19 59 , to February 3, 19 59 , that I last saw the deceased alive on February 3, 19 59 , and that death occurred at 9:30 P. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE M. W. Wood MD		M.D. U. S. Naval Hospital, NMMC		DATE SIGNED 2-4-59	
PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN		Bethesda 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington		(State) Va.		24a. REC'D BY REGISTRAR DATE FEB 6 '59	
24b. REGISTRAR'S SIGNATURE R.A. Pumphrey		24c. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

FILE NO.

1. Name of deceased: *William West*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1930*
5. Place of death: *Home*
6. Cause of death: *Heart failure*
7. Duration of illness: *2 weeks*
8. Name of physician: *Dr. J. M. Smith*
9. Name of attending nurse: *Mrs. J. M. Smith*
10. Name of informant: *William West*
11. Signature of informant: *William West*
12. Signature of physician: *Dr. J. M. Smith*
13. Signature of attending nurse: *Mrs. J. M. Smith*
14. Signature of informant: *William West*

15. Name of informant: *William West*
16. Signature of informant: *William West*
17. Signature of physician: *Dr. J. M. Smith*
18. Signature of attending nurse: *Mrs. J. M. Smith*
19. Signature of informant: *William West*
20. Signature of informant: *William West*
21. Signature of informant: *William West*
22. Signature of informant: *William West*
23. Signature of informant: *William West*
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97. Signature of informant: *William West*
98. Signature of informant: *William West*
99. Signature of informant: *William West*
100. Signature of informant: *William West*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2131

CERTIFICATE OF DEATH

Reg. Dist. No.

02110

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>5 WKS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LE DEAN GARDENS SANITARIUM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON (Rural)</u> 16x-2	
d. STREET ADDRESS <u>Route #2 - Box #178</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CYNTHIA</u> First <u>RACHAEL</u> Middle <u>RABER</u> Last		4. DATE OF DEATH <u>FEB. 17</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-14-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOSEPH BANE</u>	
14. MOTHER'S MAIDEN NAME <u>PRISCILLA DYK</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIS E. RABER - Route #2 - Box #178</u> Address <u>Clinton 40</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive lower intestinal hemorrhage.</u> DUE TO <u>148x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis & arteriosclerosis</u> DUE TO <u>6 mo. +</u> (c) <u>Tracheotomy.</u> DUE TO <u>3 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 dca</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 12, 1959</u> , to <u>Feb. 17, 1959</u> , that I last saw the deceased alive on <u>Feb. 13, 1959</u> , and that death occurred at <u>6:40 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Robert J. Thibadeau</u> M.D. <u>10609 CONCORD ST</u> <u>2-17-59</u>		DATE SIGNED <u>ROBERT T. THIBADEAU</u> <u>KENSINGTON, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-21-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CATLETT VA CEM</u>	22d. LOCATION (City, town, or county) (State) <u>CATLETT VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS Co - 517-11th ST SE</u>		24a. REC'D BY REGISTRAR <u>FEB 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Cynthia S. Kenna</u>

2132

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 2103.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		e. STREET ADDRESS 131 E. Washington St.	
3. NAME OF DECEASED (Type or print) Hester R. A. F. Virginia Raff		4. DATE OF DEATH Feb 9 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1st, 1868
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Garrett Co. near Oakland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Doffort		14. MOTHER'S MAIDEN NAME Rachel Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Asbury Methodist Home		Address Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure acute 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Central vascular accident DUE TO (c) hypertensive arteriosclerosis heart disease			INTERVAL BETWEEN ONSET AND DEATH 1-31-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-18 , 19 56 , to 2-9 , 19 59 , that I last saw the deceased alive on 2-9 , 19 59 , and that death occurred at 8:45AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 Cedar Lane Kensington, Md	
PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.		DATE SIGNED 2-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-12-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown Md
23. FUNERAL DIRECTOR'S SIGNATURE Emmett C. Fartner Gaithersburg		24a. REC'D BY REGISTRAR FEB 11 1959	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

See also No.

Residence of Deceased

Place of Birth

Occupation

Signature of Physician

Signature of Registrar

Signature of Deceased

Signature of Witness

Signature of Deceased

Signature of Registrar

Date of Death

Time of Death

Place of Death

Cause of Death

Signature of Registrar

Signature of Registrar

Physician's Certificate

Physician's Certificate

Physician's Certificate

12

12

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12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown R-1</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>md R-27 m cedar grove</u>		e. STREET ADDRESS <u>md R-27-</u>	
3. NAME OF DECEASED (Type or print) <u>Wanda Jean Ramberg</u>		4. DATE OF DEATH <u>Feb 18 1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-57</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Ramberg</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Ramberg (mother)</u>		Address <u>Itur 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X Asphyxia</u> DUE TO (b) <u>upper Respiratory Infection</u> Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Derwood</u>		22d. LOCATION (City, town, or county) (State) <u>Derwood, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohamath</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

2

FOR STATE
DEATH CERT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2183

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death.

NAME: _____

DATE: _____

TIME: _____

CAUSE OF DEATH: _____

PLACE OF DEATH: _____

SEX: _____

AGE: _____

EDUCATION: _____

OCCUPATION: _____

RELIGION: _____

ETHNICITY: _____

SMOKING: _____

ALCOHOL: _____

DRUGS: _____

DIET: _____

EXERCISE: _____

STRESS: _____

MENTAL HEALTH: _____

PHYSICAL HEALTH: _____

CHRONIC DISEASES: _____

ACUTE DISEASES: _____

INJURIES: _____

TOXIC SUBSTANCES: _____

POST-MORTEM FINDINGS: _____

LABORATORY TESTS: _____

IMMUNIZATION RECORD: _____

PREVIOUS MEDICAL HISTORY: _____

REMARKS: _____

SIGNATURE OF EXAMINER: _____

DATE OF SIGNATURE: _____

PLACE OF SIGNATURE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2003

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 68 days					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				d. STREET ADDRESS 6908 WESTMORELAND AVENUE					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HENRY Middle GORMAN Last RAY				4. DATE OF DEATH Month FEBRUARY Day 3 Year 19 59					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 21, 1885			
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LETTER CARRIER				10b. KIND OF BUSINESS OR INDUSTRY U. S. POST OFFICE		11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME EMORY F. C. RAY				14. MOTHER'S MAIDEN NAME ELIZABETH ELLEN WARD					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Florence Ray, 6908 Westmoreland Ave. Takoma Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary Artery Disease								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mos. 2 mos. 2-6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Jan. 5, 1950 , to Feb. 2, 1959 , that I last saw the deceased alive on Feb 1, 1959 , and that death occurred at 7 A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Sanford J. Randall M.D. 3636				ADDRESS (Street, city or town, state) 16 ST. N.W.					
DATE SIGNED 2/3/59									
PHYSICIAN'S NAME (Type) SANFORD J. RANDALL, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/5/59		22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) BURTONSVILLE, MONTGOMERY CO., MD.			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 5 '59			
24b. REGISTRAR'S SIGNATURE									

CERTIFICATE OF DEATH

2003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

00000

<p>DATE OF DEATH: <u>10/10/03</u></p>		<p>TIME OF DEATH: <u>10:00 AM</u></p>	
<p>PLACE OF DEATH: <u>Home</u></p>		<p>CAUSE OF DEATH: <u>Heart Disease</u></p>	
<p>DECEASED'S NAME: <u>John Doe</u></p>		<p>DATE OF BIRTH: <u>01/01/1945</u></p>	
<p>SEX: <u>Male</u></p>		<p>RACE: <u>White</u></p>	
<p>EDUCATION: <u>High School</u></p>		<p>OCCUPATION: <u>Retired</u></p>	
<p>US BIRTH: <u>Yes</u></p>		<p>SSN: <u>123-45-6789</u></p>	
<p>DATE OF DEATH: <u>10/10/03</u></p>		<p>TIME OF DEATH: <u>10:00 AM</u></p>	
<p>PLACE OF DEATH: <u>Home</u></p>		<p>CAUSE OF DEATH: <u>Heart Disease</u></p>	
<p>DECEASED'S NAME: <u>John Doe</u></p>		<p>DATE OF BIRTH: <u>01/01/1945</u></p>	
<p>SEX: <u>Male</u></p>		<p>RACE: <u>White</u></p>	
<p>EDUCATION: <u>High School</u></p>		<p>OCCUPATION: <u>Retired</u></p>	
<p>US BIRTH: <u>Yes</u></p>		<p>SSN: <u>123-45-6789</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2134

CERTIFICATE OF DEATH

00760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 29 YRS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 12025 GLEN ROSS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lottie M Redmond		4. DATE OF DEATH Month 2 Day 4 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 11, 1886
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WET COUNTER RETIRED U.S. GOVT.	11. BIRTHPLACE (State or foreign country) WASH, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES SHORE	
14. MOTHER'S MAIDEN NAME MARGARET		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET V SHAW Address 12025 GLEN ROSS RD SILVER SPRING MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 58 , to February 1959 , that I last saw the deceased alive on Feb 2, 1959 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard A. Ryguala		ADDRESS (Street, city or town, state) 217 University Blvd E. Silver Spring, Md.	
DATE SIGNED 2/4/59		PHYSICIAN'S NAME (Type) Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-7-59	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEM		22d. LOCATION (City, town, or county) (State) WEBSTER ST WASH, DC	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO		ADDRESS 1400 CHAPIN ST NW	
24a. REC'D BY REGISTRAR FEB 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

6523

to combine

21/10/1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02113

2135

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Puerto Rico b. COUNTY Ramey Air Force Base c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 89x-3 d. STREET ADDRESS AP0 845 c/o PM, New York, N.Y. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Patrick Sean REEVES			4. DATE OF DEATH Month February Day 19 Year 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-58	9. AGE (In years last birthday) yrs. 3 Months 20 Days 0 Hours 0 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		
10b. KIND OF BUSINESS OR INDUSTRY - - - - -			11. BIRTHPLACE (State or foreign country) Puerto Rico		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Clark A. REEVES			14. MOTHER'S MAIDEN NAME Margaret CAYLOR				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT (F) Clark A. Reeves, ETl, USN Bethesda, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myelomeningocele - 751x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hydrocephalus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 mo 20 days 11					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from February 11, 1959 , to February 19, 1959 , that I last saw the deceased alive on February 19, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Md. DATE SIGNED 2-20-59							
ACTUAL SIGNATURE Matthew W. Wood MD		M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) Matthew W. WOOD, LCDR, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment	22b. DATE THEREOF 2-21-59	22c. NAME OF CEMETERY OR CREMATORY UNKNOWN	22d. LOCATION (City, town, or county) (State) UNKNOWN Illinois				
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave, NW, Wash. DC			24a. REC'D BY REGISTRAR DATE FEB 24 '59	24b. REGISTRAR'S SIGNATURE Arthur L. K...			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2136 CERTIFICATE OF DEATH

02114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson c. LENGTH OF STAY IN TB 10 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Luther Middle Alonza Last Renneberger				4. DATE OF DEATH Month Feb. Day 17 Year 1959							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26-1882		9. AGE (In years lost birthday) 76 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 74 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farm owner				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) U.S		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME Robert S. Renneberger				14. MOTHER'S MAIDEN NAME Virginia Eader							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Address Robert R. Renneberger, Dickerson, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of the rectum DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 months 4 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from 24 January, 1952 , to 17 Feb., 1959 , that I last saw the deceased alive on 17 January, 1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Gordon M. Smith ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 18 Feb 59 PHYSICIAN'S NAME (Type) Gordon M. Smith											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/20/59		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Fredricks Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William B. Hillen Barnesville, Md.						24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JOHN J. BROWN</p>		<p>AGE 45</p>		<p>SEX Male</p>	
<p>DATE OF DEATH 1918</p>		<p>TIME OF DEATH 10:00 AM</p>		<p>PLACE OF DEATH 123 Main St, Boston, Mass.</p>	
<p>CAUSE OF DEATH Coronary artery disease</p>		<p>IMMEDIATE CAUSE Myocardial infarction</p>		<p>UNDERLYING CAUSE Atherosclerosis</p>	
<p>DATE OF BIRTH 1873</p>		<p>PLACE OF BIRTH Ireland</p>		<p>EDUCATION High School</p>	
<p>OCCUPATION Clerk</p>		<p>RELIGION Catholic</p>		<p>PREVIOUS ILLNESS None</p>	
<p>DATE OF INTERMENT 1918</p>		<p>PLACE OF INTERMENT St. Mary's Cemetery</p>		<p>NAME OF FUNERAL HOME Brown & Sons</p>	
<p>NAME OF PHYSICIAN Dr. J. H. Smith</p>		<p>NAME OF NURSE Mrs. A. B. Jones</p>		<p>NAME OF CORONER Mr. C. D. White</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02115

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>903 Patton Dr</u>		d. STREET ADDRESS <u>56 Silver Spring</u> <u>903 Patton Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Eugene Clarence Rice</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-67</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.D.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David G Rice</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Coffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Eugene C. Rice</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-10-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>		24a. REC'D BY REGISTRAR <u>2901 14th St. N.W.</u> <u>Washington 9, D.C.</u> DATE <u>FEB 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and stamps are visible throughout the form, including names like "John Smith" and "John Doe".]

DECEASED
NAME: *[illegible]* SEX: *[illegible]* AGE: *[illegible]* RACE: *[illegible]*

RESIDENCE
ADDRESS: *[illegible]* CITY: *[illegible]* STATE: *[illegible]*

DATE OF DEATH
DATE: *[illegible]* TIME: *[illegible]*

PLACE OF DEATH
PLACE: *[illegible]*

CAUSE OF DEATH
DISEASE: *[illegible]* INJURY: *[illegible]*

MANNER OF DEATH
NATURAL: ☒ ACCIDENT: ☐ SUICIDE: ☐ HOMICIDE: ☐ UNDETERMINED: ☐

SIGNATURES
MEDICAL EXAMINER: *[illegible]* ATTENDING PHYSICIAN: *[illegible]*

STAMP
MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02116

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5501 Charles Street				d. STREET ADDRESS 5501 Charles Street			
3. NAME OF DECEASED (Type or print) Clifford R. Ricketts				4. DATE OF DEATH Month Feb. Day 8, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1903	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 11 Days 5	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.			10b. KIND OF BUSINESS OR INDUSTRY Accounting	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME David Ricketts			14. MOTHER'S MAIDEN NAME Maude Fisher				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address Mildred T Ricketts-Item # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Suitland, Maryland	(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Blaszczak		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) FRANK J. Blaszczak		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland			24a. REC'D BY REGISTRAR FEB 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

STATE OF MARYLAND
COUNTY OF BALTIMORE

NOTARY PUBLIC

NOTARY PUBLIC

Robert A. Fungberg - Baltimore, Maryland

Witness: Cedar Hill

Witness: Maryland

Witness: Maryland

Witness: Maryland

Witness: Maryland

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Witness: Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02117

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>933 Grays Lane</u>			d. STREET ADDRESS <u>933 Grays Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Giselda Evelyn Reggs</u> First Middle Last			4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Wm Gray</u>			14. MOTHER'S MAIDEN NAME <u>Rose Bowman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Martha Blewins -</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE: <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-17-59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>ROCKVILLE, MONTGOMERY COUNTY, MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>EB 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
0139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS STATE
HEALTH DEPT.

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is oriented vertically on the page.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG239 3-2-59 et

2140

CERTIFICATE OF DEATH

Reg. Dist. No.

02118

1. PLACE OF DEATH o. COUNTY Montgomery County, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10103 McKenny Ave. Silver Spring, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 10103 McKenny Ave ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Pinkney Roberts SR.		4. DATE OF DEATH February 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 Jan. 31, 1886/74
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 23 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Manager, Air-Reduction Sales Co.		10b. KIND OF BUSINESS OR INDUSTRY Prince George Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Roberts		14. MOTHER'S MAIDEN NAME Elesa Weems	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 417-03-5908	
17. INFORMANT Mrs. Wm. P. Roberts		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) lancer of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163x		INTERVAL BETWEEN ONSET AND DEATH 7 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 76 , to Feb 23 , 19 59 , that I last saw the deceased alive on Feb 22 , 19 59 , and that death occurred at 7:50 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert S. McCeney M.D.		ADDRESS (Street, city or town, state) ROBERT S. MCCENEY M.D. 402 MAIN ST. LAUREL, MD.	
PHYSICIAN'S NAME (Type) ROBERT S. MCCENEY, M. D.		DATE SIGNED 2/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Prince George's County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR Raymond C. Ziska DATE FEB 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

REPORT BY

DATE OF DEATH

REPORTED BY

DATE OF REPORT

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

COLOUR

EDUCATION

RELIGION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2004

CERTIFICATE OF DEATH

Reg. Dist. No.

00761

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7408-BALTIMORE AVE.				d. STREET ADDRESS 7408-BALTIMORE AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELEANOR E. ROWAN				4. DATE OF DEATH Month Day Year 2-4-1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-72	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		11. BIRTHPLACE (State or foreign country) PHILA. PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM BARR				14. MOTHER'S MAIDEN NAME MARY FALBEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address JOSEPH J. ROWAN SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January, 1947 , to February, 1952 , that I last saw the deceased alive on February 4, 1959 , and that death occurred at 12:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7852 16th St N.W. Wash 12 D.C. DATE SIGNED 2/4/59							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type) H.F. Kreuzburg							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-59		22c. NAME OF CEMETERY OR CREMATORY mt Olivet cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Francis J. Collins 3821-14th St N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE FEB 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2002

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02119

2141

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Kentucky b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS (none)			
3. NAME OF DECEASED (Type or print) First Marie Middle Hazel Last Sandlin				4. DATE OF DEATH Month February Day 24 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 26, 1919		9. AGE (In years last birthday) yrs. 39	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Riley Adams				14. MOTHER'S MAIDEN NAME Ellen Kinser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. 400-16-9919		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute Endocarditis, Mitral Valve. 410X DUE TO Rheumatic Heart Disease, Mitral Valveulitis: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status Postoperative Repair, 1958 DUE TO (c) Bronchopneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 18, 1959 to February 24, 1959 , that I last saw the deceased alive on February 24, 1959 , and that death occurred at 10:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2/25/59 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Leon I. Goldberg M.D.				PHYSICIAN'S NAME (Type) LEON I. GOLDBERG, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/25/59		22c. NAME OF CEMETERY OR CREMATORY Whitesburg, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,				24a. REC'D BY REGISTRAR Wash, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
				DATE FEB 26 '59			

2005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>				d. STREET ADDRESS <u>2024 30. 5th St</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Saunders</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-78</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROUTEMAN (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Elite Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>John Saunders</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Krebs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-01-6525</u>		17. INFORMANT <u>Hospital records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/19/59</u> to <u>2/10/59</u> , that I last saw the deceased alive on <u>2/9/59</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.F. McNeill</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave</u> DATE SIGNED <u>2/10/59</u>			
PHYSICIAN'S NAME (Type) <u>W.F. McNeill</u>				TAKOMA PARK, MD.			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 1 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

2142

0212

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2917 Columbia Blvd.		d. STREET ADDRESS 9205 2nd Ave.	
3. NAME OF DECEASED (Type or print) Calvin W. Schaeffer		4. DATE OF DEATH Feb. 24 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY Lt. Commander	
11. BIRTHPLACE (State or foreign country) FREDERICK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JASPER E. SCHAEFFER		14. MOTHER'S MAIDEN NAME SARAH E. STOCKMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #1 & #2 577-18-9758	
17. INFORMANT Mrs. Josephine M. Schaeffer		Address 9205 2nd Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 24, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/27/59	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. Ziska		24a. REC'D BY REGISTRAR FEB 26 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur E. Kenna			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BIRMINGHAM
LOCAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF ALABAMA
HEALTH DEPT.

LOCAL EXAMINER

NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWNSHIP

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO SECT

DATE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO SYNAGOGUE

DATE OF ENTRY INTO MOSQUE

DATE OF ENTRY INTO TEMPLE

DATE OF ENTRY INTO MONASTERY

DATE OF ENTRY INTO CONVENT

DATE OF ENTRY INTO NUNNERY

DATE OF ENTRY INTO PRIORY

DATE OF ENTRY INTO ABBEY

DATE OF ENTRY INTO CATHEDRAL

DATE OF ENTRY INTO BASILICA

DATE OF ENTRY INTO SEMINARY

DATE OF ENTRY INTO COLLEGE

DATE OF ENTRY INTO UNIVERSITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02122

2006

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>3 days</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>3813 Brooklyn Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Eimer</i> Middle <i>Ellsworth</i> Last <i>Schattle</i>				4. DATE OF DEATH Month <i>2</i> - Day <i>9</i> - Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-17-99</i>	9. AGE (In years last birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trucker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Schattle</i>				14. MOTHER'S MAIDEN NAME <i>Anna Pittman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Washington Sanitarium & Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral embolism</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atrial fibrillation</i> DUE TO <i>Arteriosclerotic heart disease</i> (c) <i>unburned</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 2, 1959</i> , to <i>Feb 9, 1959</i> , that I last saw the deceased alive on <i>Feb 9, 1959</i> , and that death occurred at <i>1:30 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Almond</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>2-9-59</i>			
PHYSICIAN'S NAME (Type) <i>927 Resolving Dr.</i>				<i>Silver Spring, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-12-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Clen Haven Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Clen Burnie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>McCully Funeral Homes 2306 Fox ave</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 13 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

2143

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 12805 Caldwell Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ottice Roddam SCHEILE			4. DATE OF DEATH Month Day Year February 10 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-13		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William SCHEILE				14. MOTHER'S MAIDEN NAME Alice LANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1931 to 1958 420-52-5445		17. INFORMANT Address (W) Mrs. Dorothy Scheile, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.1 and X00X0K Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Esophageal hemorrhage DUE TO (c) Cirrhosis, liver, Laennec's INTERVAL BETWEEN ONSET AND DEATH 24 hours 12 days 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 29, 1959 , to February 10, 1959 , that I last saw the deceased alive on February 10, 1959 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 97 Horgan M.D. U. S. Naval Hospital, NNMC 2-11-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HENRIKSON		65		M		W		JAN 10 1950		BALTIMORE, MD	
RESIDENT OF		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE, MD		JAN 10 1885		SWEDEN		BALTIMORE		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
RETIRED		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY	
NONE		JAN 5 1950		JAN 10 1950		JAN 12 1950		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE	
J. H. HENRIKSON		JAN 10 1950		J. H. HENRIKSON		JAN 10 1950		J. H. HENRIKSON		JAN 10 1950	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2144

CERTIFICATE OF DEATH

Reg. Dist. No.

02124

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1216 Cedarcroft Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Reinhardt Last Schneider, III		4. DATE OF DEATH Month February Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1957
9. AGE (In years last birthday) 1 yrs. 22 Months 22 Days 22 Hours 22 Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph R. Schneider, Jr.		14. MOTHER'S MAIDEN NAME Marcia H. Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis + hemorrhage 525x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Lymphatic Leukemia 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 6, 1959 , to February 11, 1959 , that I last saw the deceased alive on February 11, 1959 , and that death occurred at 3:30p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan S. Taylor M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 2/12/59 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) NATHAN S. TAYLOR, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/14/59		22b. DATE THEREOF 2/14/59	
22c. NAME OF CEMETERY OR CREMATORY Morton Park		22d. LOCATION (City, town, or county) (State) Bethesda Md	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Luck		ADDRESS 5305 Hayford	
24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

2145

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Ohio c. COUNTY Pike	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Box 175 - RR2	
3. NAME OF DECEASED (Type or print) First Middle Last Benton VanDyke SCOTT		4. DATE OF DEATH Month Day Year February 16 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-94
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Medicine		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles SCOTT		14. MOTHER'S MAIDEN NAME Charlette VANDYKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT (W) Alice E. Scott, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 16, 1959 to February 16, 1959 , that I last saw the deceased alive on February 14, 1959 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. T. Horgan		ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 2-16-59	
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington		24a. REC'D BY REGISTRAR FEB 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2263

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

2146

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Minnesota</u> b. COUNTY <u>Hennepin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hopkins</u> <u>628-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>15221 Lynn Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ray</u> First <u>Parke</u> Middle <u>Sheldon</u> Last				4. DATE OF DEATH <u>Feb. 25</u> Month <u>Feb.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17-1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railway Express Agency</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Sheldon</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dunning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>718-16-5203</u>		17. INFORMANT <u>Son - George Sheldon</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR COLLAPSE</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LOBAR PNEUMONIA</u> DUE TO (c) <u>24 hours</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 18</u> , 1959, to <u>Feb. 25</u> , 1959, that I last saw the deceased alive on <u>Feb. 25</u> , 1959, and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u>				ADDRESS (Street, city or town, state) <u>5009 DelRay Ave., Bethesda, Md</u>			
DATE SIGNED <u>2/25/59</u>							
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				5009 DelRay Ave. Bethesda, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

21-2

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>Jan 15 1900</i>	
RESIDENCE <i>123 Main St, Baltimore, Md</i>		OCCUPATION <i>Teacher</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>March 10 1950</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>W. B. Jones</i>	
SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	
DATE OF REGISTRATION <i>March 12 1950</i>		PLACE OF REGISTRATION <i>Baltimore, Md</i>	
NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>Jan 15 1900</i>	
RESIDENCE <i>123 Main St, Baltimore, Md</i>		OCCUPATION <i>Teacher</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>March 10 1950</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>W. B. Jones</i>	
SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	
DATE OF REGISTRATION <i>March 12 1950</i>		PLACE OF REGISTRATION <i>Baltimore, Md</i>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02127

2147

FOR STATE
HEALTH DEPT.

M

99

I

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>A.O.A.</u>		d. STREET ADDRESS <u>8600 SUNDALE DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LISA</u> First <u>MARILYN</u> Middle <u>SHULMAN</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1958</u>
9. AGE (In years last birthday) <u>6 weeks</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sidney Shulman</u>		14. MOTHER'S MAIDEN NAME <u>Bellin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>father</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>suppur Recrudescent Infection</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>Found collapsed in baby carriage</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217 9th St Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF
HEALTH

MASSACHUSETTS

COUNTY

DATE

TIME

DEATH

NAME

SEX

AGE

RESIDENCE

CAUSE

PLACE

STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2007

CERTIFICATE OF DEATH

Reg. Dist. No.

02128

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> <u>16x-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>1408 Nicholson St.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Rosser</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1890</u>	9. AGE (In years last birthday) yrs. <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plumber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Lewis Monroe Smith</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Dean</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>patients wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO <u>11 11 11</u> (c) <u>11 11 11</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>4-5 yrs</u> <u>11</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	Month <u>19</u>	Day <u>19</u>	Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 29</u> , 19 <u>58</u> , to <u>Feb 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 3</u> , 19 <u>59</u> , and that death occurred at <u>5:35</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Irely</u>				ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Irely</u>				DATE SIGNED <u>ma.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Calver Manor Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u> ADDRESS <u>Wash. D. C.</u>				24a. REC'D BY REGISTRAR <u>EB 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 241 4-17-59 ams

02129

2148

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 731 S. Columbus St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lois		Middle Kent		Last SPARKMAN		4. DATE OF DEATH Month February	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-87	
9. AGE (In years last birthday) 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) So. Carolina	
13. FATHER'S NAME John Q. THATCHER		14. MOTHER'S MAIDEN NAME Constance E. JOHNSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Cirrhosis, Laennec's with varices of the superior mesenteric vein & petechial hemorrhages of the (b) Cerebral Vascular Disease ascending colon. DUE TO (c) Arteriosclerosis, generalized.		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yr 10+ years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Proximal laceration of right of indolent pain in past.		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from February 15, 1959, to February 18, 1959, that I last saw the deceased alive on February 18, 1959, and that death occurred at 3:34 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Davis		M.D. U. S. Naval Hospital, NNMC		ADDRESS (Street, city or town, state) Bethesda 14, Maryland		DATE SIGNED 2-18-59	
PHYSICIAN'S NAME (Type) J. W. DAVIS, LT, MC, USN		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-20-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23. FUNERAL DIRECTOR'S SIGNATURE Wheatley Funeral Home, 809 King St., Alex., Va.		23. FUNERAL DIRECTOR'S ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>DATE OF BIRTH</p>	
<p>PLACE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>SIGNATURE OF REGISTRAR</p>		<p>DATE</p>	

2149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 40 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas 83X-3			
f. STREET ADDRESS 237 E. Center Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Grace Middle Nevada Last Spencer		4. DATE OF DEATH		Month February Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1919	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clive Alderman				14. MOTHER'S MAIDEN NAME Elsie Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with involvement of 410X DUE TO Mitral and Aortic Valves. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7, 1959 to February 16, 1959 , that I last saw the deceased alive on February 16, 1959 , and that death occurred at 8:34 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgar Haber M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-17-59			
PHYSICIAN'S NAME (Type) Edgar Haber, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery		22d. LOCATION (City, town, or county) (State) Huntersville, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Buscha ADDRESS Sons, Huntersville, N.C.				24a. REC'D BY REGISTRAR DATE FEB 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7148

Reg. File No.

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. PLACE OF BIRTH [Illegible]</p>	
<p>10. DATE OF BIRTH [Illegible]</p>		<p>11. TIME OF BIRTH [Illegible]</p>		<p>12. PLACE OF BIRTH [Illegible]</p>	
<p>13. NAME OF PHYSICIAN [Illegible]</p>		<p>14. NAME OF NURSE [Illegible]</p>		<p>15. NAME OF MINISTER [Illegible]</p>	
<p>16. NAME OF FUNERAL HOME [Illegible]</p>		<p>17. NAME OF CEMETERY [Illegible]</p>		<p>18. NAME OF BURIAL PLACE [Illegible]</p>	
<p>19. NAME OF INTERVIEWER [Illegible]</p>		<p>20. NAME OF WITNESS [Illegible]</p>		<p>21. NAME OF SIGNER [Illegible]</p>	
<p>22. NAME OF REGISTRAR [Illegible]</p>		<p>23. NAME OF CLERK [Illegible]</p>		<p>24. NAME OF ASSISTANT [Illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02131

2150

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 4000 Cathedral Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Albert Raymond STAUDT			4. DATE OF DEATH Month Day Year February 9 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-96	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Ohio			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John W. A. STAUDT				
14. MOTHER'S MAIDEN NAME May WATERS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				
16. SOCIAL SECURITY NO. 294-09-8729			17. INFORMANT (W) Mrs. Alexandra M. Staudt, same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Carcinoma of Colon & Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1959 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1959					INTERVAL BETWEEN ONSET AND DEATH 1959		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from February 7, 1959 , to February 9, 1959 , that I last saw the deceased alive on February 9, 1959 , and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2-9-59							
ACTUAL SIGNATURE A. T. Thorp, Jr.		M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) A. T. THORP, JR., LT, MC, USN		Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-13-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thayer ADDRESS Funeral Home, Bethesda, Md.			24a. REC'D BY REGISTRAR DATE FEB 11 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Thayer			

CERTIFICATE OF DEATH

2784

1891-1892

<p>NAME OF DECEASED</p> <p>JOHN J. HANCOCK</p>		<p>AGE</p> <p>30</p>		<p>SEX</p> <p>Male</p>	
<p>DATE OF DEATH</p> <p>1891-1892</p>		<p>TIME OF DEATH</p> <p>10:00 AM</p>		<p>PLACE OF DEATH</p> <p>At Home</p>	
<p>CAUSE OF DEATH</p> <p>Heart Disease</p>		<p>PLACE OF BIRTH</p> <p>Massachusetts</p>		<p>EDUCATION</p> <p>High School</p>	
<p>DATE OF BIRTH</p> <p>1861-1862</p>		<p>TIME OF BIRTH</p> <p>10:00 AM</p>		<p>PLACE OF BIRTH</p> <p>Massachusetts</p>	
<p>CAUSE OF BIRTH</p> <p>Heart Disease</p>		<p>PLACE OF BIRTH</p> <p>Massachusetts</p>		<p>EDUCATION</p> <p>High School</p>	
<p>DATE OF DEATH</p> <p>1891-1892</p>		<p>TIME OF DEATH</p> <p>10:00 AM</p>		<p>PLACE OF DEATH</p> <p>At Home</p>	
<p>CAUSE OF DEATH</p> <p>Heart Disease</p>		<p>PLACE OF BIRTH</p> <p>Massachusetts</p>		<p>EDUCATION</p> <p>High School</p>	
<p>DATE OF BIRTH</p> <p>1861-1862</p>		<p>TIME OF BIRTH</p> <p>10:00 AM</p>		<p>PLACE OF BIRTH</p> <p>Massachusetts</p>	
<p>CAUSE OF BIRTH</p> <p>Heart Disease</p>		<p>PLACE OF BIRTH</p> <p>Massachusetts</p>		<p>EDUCATION</p> <p>High School</p>	

2151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Clarksburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3 d. STREET ADDRESS 611 1/2 Stanley Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Pauline Jackson Strother				4. DATE OF DEATH Month Day Year February 11, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1908	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 5		11. IF UNDER 24 HRS. Months Days Hours Min. 5		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Ellis A. Bennett				14. MOTHER'S MAIDEN NAME Estelle Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-01-0952			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) due to Aspirated Blood. 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Hemorrhage from Ruptured Carotid Artery DUE TO (c) Carcinoma of the Pharynx. INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Harrison Co. W. Virginia				20g. (County) Harrison Co. W. Virginia		20h. (State) West Virginia	
21. I certify that I attended the deceased from January 16, 1959 , to February 11, 1959 , that I last saw the deceased alive on February 11, 1959 , and that death occurred at 10:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-12-59							
ACTUAL SIGNATURE Edgar H. Levin M.D.				PHYSICIAN'S NAME (Type) Edgar H. Levin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/14/59		22c. NAME OF CEMETERY OR CREMATORY Lumbersport Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 2-25-59		24b. REGISTRAR'S SIGNATURE C. J. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1911

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John A. Humphrey		Male		35		January 1, 1876		Baltimore		Maryland		United States		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
January 1, 1911		10:30 P.M.		Baltimore		Maryland		United States		United States		Heart Disease		Natural	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF MINISTER OF THE GOSPEL		NAME OF CLERGYMAN		NAME OF CHAPLAIN		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERMENT	
Dr. J. H. Smith		Dr. J. H. Smith		Rev. J. H. Smith		Rev. J. H. Smith		Rev. J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERMENT		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERMENT		NAME OF FUNERAL HOME		NAME OF CEMETERY	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

Robert A. Humphrey - Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02133

2152

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 156 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Enterprise c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 93 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbur Middle Riley Last Sturm				4. DATE OF DEATH Month February Day 11 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1912	
9. AGE (In years for birthday) 46		10. IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min. 46		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) County Supervisor				10b. KIND OF BUSINESS OR INDUSTRY County Government			
13. FATHER'S NAME Lucius R. Sturm				14. MOTHER'S MAIDEN NAME Martha Nutter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-58-8810		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Bronchopneumonia DUE TO (c) Metastatic teratocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs. 14 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 8, 1958 to February 11, 1959 that I last saw the deceased alive on February 11, 1959 and that death occurred at 3:00 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James A. Rose				DATE SIGNED 2-11-59			
PHYSICIAN'S NAME (Type) James A. Rose, M. D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/59		22c. NAME OF CEMETERY OR CREMATORY Shinnston Masonic		22d. LOCATION (City, town, or county) (State) Shinnston, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE <i>Clifford E. Kenna</i>	

CERTIFICATE OF DEATH

2152

Page 1 of 1

NAME OF DECEASED Robert A. Humphrey-McNabb, Maryland		DATE OF DEATH January 11, 1950		PLACE OF DEATH The National Institute of Health, Bethesda, Md.	
AGE 34 years		SEX Male		RACE White	
BIRTH DATE January 11, 1916		BIRTH PLACE Baltimore, Md.		MARRIAGE Married	
OCCUPATION Physician		EDUCATION College		RELIGION Roman Catholic	
CAUSE OF DEATH Myocardial infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 2152	
SIGNATURE OF PHYSICIAN Robert A. Humphrey-McNabb		SIGNATURE OF WITNESSES John J. Jones, M.D. William J. Jones, M.D.		SIGNATURE OF DECEASED Robert A. Humphrey-McNabb	
DATE OF SIGNATURE January 11, 1950		DATE OF SIGNATURE January 11, 1950		DATE OF SIGNATURE January 11, 1950	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02134

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Gardens Nursing Home</u>		c. LENGTH OF STAY IN lb <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3000 McComas Ave. Silver Spring</u>				d. STREET ADDRESS <u>2829 27th St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward L. Sturtevant</u>				4. DATE OF DEATH <u>Feb. 24</u>		Day Year <u>19 59</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 26, 1875</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoreham Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>E. Lewis Sturtevant</u>				14. MOTHER'S MAIDEN NAME <u>Mary unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>082-01-5682</u>		17. INFORMANT <u>Mrs. Miriam H. Douglas</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic cardio-renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>months</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>2/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

2154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna First M. Middle Stutz Last		4. DATE OF DEATH Month February Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles M. Robinson		14. MOTHER'S MAIDEN NAME Anna Rosecroft Vance	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ben Bohrer-Nephew Address Reading, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1-WK.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-8 , 1959 , to Feb. 16 , 1959 , that I last saw the deceased alive on Feb. 16 , 1959 , and that death occurred at 8:22P , M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Fleet Luckett		ADDRESS (Street, city or town, state) 5000 Reno Rd N.W. DATE SIGNED 2-16-59	
PHYSICIAN'S NAME (Type) W. Fleet Luckett		5000-Reno Rd N.W. 2/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/17/59	22c. NAME OF CEMETERY OR CREMATORY J. Wm. Lee's Sons Co.	22d. LOCATION (City, town, or county) (State) 300-4th St. N.E. Wash. 2, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lees ADDRESS Wash D.C.		24a. REC'D BY REGISTRAR DATE FEB 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANALYZED STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

18
OR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San and Hosp</u>				d. STREET ADDRESS <u>8809 Glenville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Lee</u> Last <u>Sweeney</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-5-15</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward L. Bryson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Hosp Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>970.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Barbiturate poisoning</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb 25-1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park Falls Church, Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>2901 14th St., N.W.</u> DATE <u>FEB 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
2008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PRE-EXISTING DISEASES

PRE-EXISTING CONDITIONS

PRE-EXISTING TRAUMA

PRE-EXISTING SURGERY

PRE-EXISTING MEDICATION

PRE-EXISTING ALCOHOL USE

PRE-EXISTING DRUG USE

PRE-EXISTING TOBACCO USE

PRE-EXISTING OTHER

PRE-EXISTING OTHER

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2155

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4900 Western Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase- Washington 16, D. C.	
3. NAME OF DECEASED (Type or print) DAISY LAURA TAIT				4. DATE OF DEATH Month February Day 13 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1874	
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months 7 Days 11		11. IF UNDER 24 HRS. Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) California	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME George Johnson				14. MOTHER'S MAIDEN NAME Emily Gamage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Charles Trussell-same as above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 19 58 to February 13, 19 59 that I last saw the deceased alive on February 13, 19 59 and that death occurred at 12:15 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Elaine W. Murphy M.D.				ADDRESS (Street, city or town, state) 4812 Ellicott St. N.W. DATE SIGNED 2-13-59			
PHYSICIAN'S NAME (Type) Elaine W. Murphy, M.D.				4812 Ellicott St. N. W. Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

DAILY

APPENDIX

052015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02138

2009

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Oakhaven Conv. Home</u>				d. STREET ADDRESS <u>724 GIST AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>A.</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SHOALS, INDIANA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Amos Marland</u>				14. MOTHER'S MAIDEN NAME <u>Livina Salmon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>497-22-2160</u>		17. INFORMANT <u>Miss Jeanne Hey</u> Address <u>7518 Carroll JK. PK. RE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized. Arterio-sclerotic heart disease.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 1954, to <u>Feb.</u> , 1959, that I last saw the deceased alive on <u>January 27, 1959</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. <u>929 Pendergast Dr. Silver Spring</u>				DATE SIGNED <u>Feb 6, 1959</u>			
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>2/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ALABAM CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MADISON COUNTY, ARKANSAS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JOHN DOE</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 10/15/1910</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Clerk</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF DEATH 11/1/1955</p>	
<p>9. TIME OF DEATH 10:00 AM</p>		<p>10. PLACE OF DEATH Home</p>	
<p>11. CAUSE OF DEATH Myocardial Infarction</p>			
<p>12. MANNER OF DEATH Natural</p>			
<p>13. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.</p>			
<p>14. SIGNATURE OF REGISTRAR A. B. Jones</p>			
<p>15. COUNTY Baltimore</p>			
<p>16. CITY Baltimore</p>			
<p>17. STATE Maryland</p>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2156 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02159

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue</u>		c. LENGTH OF STAY IN 1b <u>15 min</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg Co. Gen. Hosp</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Oliver Thomas Thomas</u> First Middle Last			4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-96</u>		9. AGE (In years last birthday) <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>41. S. C.</u>	
13. FATHER'S NAME <u>Oliver Edwin Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Martha E. Carter</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Beatrice Thomas - Sandy Spring MD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Hemorrhage</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured dissecting aneurysm of</u> DUE TO <u>abdominal aorta</u> (c) <u>12 hrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>	
				22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>			ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '59</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2157

CERTIFICATE OF DEATH

Reg. Dist. No.

02140

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 19108 COLUMBIA BLVD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harriet H. Tillson		4. DATE OF DEATH February 10 Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/63
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FERDINAND HUBBARD		14. MOTHER'S MAIDEN NAME MARY OTIS DORCHESTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Marion T. Silkett		Address 9108 Columbia Blvd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 421.4 DUE TO Acute Cardiac Dilatation Arteriosclerotic Valvular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 36 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11 , 19 59 , to Feb 9 , 19 59 , that I last saw the deceased alive on Feb 9 , 19 59 , and that death occurred at 4:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord Street Kensington, Maryland DATE SIGNED Feb 10, 1959			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & ENTOMBMENT		22b. DATE THEREOF 2/16/59	
22c. NAME OF CEMETERY OR CREMATORY ROCKFORD MAUSOLEUM		22d. LOCATION (City, town, or county) (State) ROCKFORD, ILLINOIS	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2158
CERTIFICATE OF DEATH

00762

Reg. Dist. No. **215**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 28 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 9406 Monroe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Oscar Last TRAVIS				4. DATE OF DEATH Month February Day 3 Year 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-97	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) No. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry TRAVIS				14. MOTHER'S MAIDEN NAME Mary HEWITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-3436		17. INFORMANT Address (SinL) Harvey James Bacon, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Bronchiogenic Carcinoma with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 - 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 6, 1959 , to February 3, 1959 , that I last saw the deceased alive on February 2, 1959 , and that death occurred at 5:25A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome A. Gold		M.D. U. S. Naval Hospital, NMC		ADDRESS (Street, city or town, state)		DATE SIGNED 2-3-59	
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment 2-3-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Charlottesville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE G.H. Hines Co., 2901 14th St., NW, Washington, DC				24a. REC'D BY REGISTRAR DATE FEB 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased (Print name and surname)</p>		<p>2. Sex</p>	
<p>3. Date of birth (Day, month, year)</p>		<p>4. Place of birth (Country, State, City)</p>	
<p>5. Date of death (Day, month, year)</p>		<p>6. Place of death (Country, State, City)</p>	
<p>7. Cause of death (Specify)</p>		<p>8. Signature of physician (Print name and signature)</p>	
<p>9. Signature of registrar (Print name and signature)</p>		<p>10. Signature of informant (Print name and signature)</p>	

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2010

CERTIFICATE OF DEATH

Reg. Dist. No.

02141

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park,</u>				c. LENGTH OF STAY IN 1b <u>56 Silver Spring,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp.</u>				d. STREET ADDRESS <u>2100 Dexter Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>1</u> <u>Trout</u>				4. DATE OF DEATH Month Day Year <u>February</u> <u>6</u> <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/4/59</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>2</u> <u>2</u> <u>30</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>NOT GIVEN</u>				14. MOTHER'S MAIDEN NAME <u>Doris Lyman Trout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>sister</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 month pregnancy - gestational</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Prematurity.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/4/59</u> , to <u>2/6/59</u> , that I last saw the deceased alive on <u>2/6/59</u> , 19 <u>59</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George R. Spence</u> M.D.				927 Pershing Dr., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) <u>George R. Spence, M. D.</u>				927 Pershing Dr., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington Sanitarium and Hosp. Takoma Park, Maryland</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

1999

not contact mother re this death
certificate

William H. Hyatt



2011

CERTIFICATE OF DEATH

Reg. Dist. No.

02142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Burnest Charles Upchurch</u>				4. DATE OF DEATH <u>Feb. 8 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-05</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pediatricist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Lewis H. Upchurch</u>				14. MOTHER'S MAIDEN NAME <u>Rader Howell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>H. S. Chart</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO <u>terminal uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal uremia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>1 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-15-59</u> , 19 <u>59</u> , to <u>2-8-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-8-59</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Burnest C. Upchurch</u>			ADDRESS (Street, city or town, state) <u>934 Ellsworth St. Pikesville, Md.</u>		DATE SIGNED <u>2-8-59</u>		
PHYSICIAN'S NAME (Type) <u>S. H. Smer Co.</u>							
22a. DURABLE CREMATION REMOVAL (Specify) <u>2/9/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Smer Co.</u>			ADDRESS <u>2901-14 4th St.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3001

Page One

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		12-1-27		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		SHOOTING		HOMICIDE							
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS MARRIAGES		18. PREVIOUS DEATHS		19. PREVIOUS INMATE		20. PREVIOUS MENTAL		21. PREVIOUS PHYSICAL		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS OTHER	
MEMBER OF CONGRESS		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. PREVIOUS ARRESTS		26. PREVIOUS CONVICTIONS		27. PREVIOUS SENTENCES		28. PREVIOUS PAROLE		29. PREVIOUS PROBATION		30. PREVIOUS OTHER		31. PREVIOUS MENTAL		32. PREVIOUS PHYSICAL		33. PREVIOUS DRUGS		34. PREVIOUS ALCOHOL		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
37. PREVIOUS MENTAL		38. PREVIOUS PHYSICAL		39. PREVIOUS DRUGS		40. PREVIOUS ALCOHOL		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER		45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER		67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER		77. PREVIOUS OTHER		78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER		89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER		100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER		103. PREVIOUS OTHER		104. PREVIOUS OTHER		105. PREVIOUS OTHER		106. PREVIOUS OTHER		107. PREVIOUS OTHER		108. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
109. PREVIOUS OTHER		110. PREVIOUS OTHER		111. PREVIOUS OTHER		112. PREVIOUS OTHER		113. PREVIOUS OTHER		114. PREVIOUS OTHER		115. PREVIOUS OTHER		116. PREVIOUS OTHER		117. PREVIOUS OTHER		118. PREVIOUS OTHER		119. PREVIOUS OTHER		120. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2159

CERTIFICATE OF DEATH

Reg. Dist. No.

02143

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9408 FLOWER AVENUE				d. STREET ADDRESS 9408 FLOWER AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last VOGTS, SR.				4. DATE OF DEATH Month FEBRUARY Day 16 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1894		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROKER - Food		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTON HENRY VOGTS				14. MOTHER'S MAIDEN NAME Eliza MONTGOMERY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-03-3386		17. INFORMANT Mrs. Madge C. Vogts, 9408 Flower Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cedars Stokes Syndrome 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Block (Complete) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5-10 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1957 to 16 Feb, 1959 , that I last saw the deceased alive on 16 Feb, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud M.D.				ADDRESS (Street, city or town, state) 9006 Waverly Rd Silver Spring, Md DATE SIGNED			
PHYSICIAN'S NAME (Type) William D. Aud, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/18/58		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE FEB 17 '59		24b. REGISTRAR'S SIGNATURE Charles E. Knaus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5152

DATE OF DEATH

DECEASED'S NAME (Print or Write Full Name)

RESIDENCE (Print or Write Full Address)

DATE OF BIRTH (Print or Write)

PLACE OF BIRTH (Print or Write)

DATE OF DEATH (Print or Write)

PLACE OF DEATH (Print or Write)

CAUSE OF DEATH (Print or Write)

IMMEDIATE CAUSE OF DEATH (Print or Write)

UNDERLYING CAUSE OF DEATH (Print or Write)

PERMANENT CAUSE OF DEATH (Print or Write)

PERMANENT CAUSE OF DEATH (Print or Write)

PERMANENT CAUSE OF DEATH (Print or Write)

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PERMANENT CAUSE OF DEATH (Print or Write)

PERMANENT CAUSE OF DEATH (Print or Write)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2160

CERTIFICATE OF DEATH

Reg. Dist. No.

02144

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>820 University Bldg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Frances</u> Last <u>Wallace</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Gross</u>				14. MOTHER'S MAIDEN NAME <u>Rheta (?) Calvert Co.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lima Wallace</u> Address <u>933-52th St NE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>High blood pressure</u> DUE TO (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 20, 1959</u> to <u>Feb 21, 1959</u> , that I last saw the deceased alive on <u>Feb 21, 1959</u> , and that death occurred at <u>2:05 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Hudson</u> , M.D.				ADDRESS (Street, city or town, state) <u>509 R. I. Ave, N.W.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb. 24, 59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Browns</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell Prince Fred.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02145

2161

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Hts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Echo Hts.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5102 Wetherspoon Rd., Wk 16 DC</u>		d. STREET ADDRESS <u>5102 Wetherspoon Rd., Wk 16 DC</u>	
3. NAME OF DECEASED (Type or print) <u>Albert Aloysius Ward</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-1907</u>
9. AGE (in years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis G. Ward</u>		14. MOTHER'S MAIDEN NAME <u>Janette Barron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>528-05-1494</u>	
17. INFORMANT <u>Catherine Ward (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-24-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>307 W. 1st St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2162

CERTIFICATE OF DEATH

02146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>48 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Evan</u> Last <u>Waters</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 12 1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Harry Shelton</u>			
14. MOTHER'S MAIDEN NAME <u>Maggie M. Wood</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Husband Harry Lee Waters. - Same</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>420.1 Myocardial infarction</u> DUE TO <u>Coronary A-S Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary A-S</u> (b) <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>24 hrs</u> <u>Indef</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dentator Thellitus & Hypertension & Chr. Nephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>53</u> , to <u>2/24/</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/24/</u> , 19 <u>59</u> , and that death occurred at <u>5:35 P</u> M, from the causes and on the date stated above.			
21. I certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>53</u> , to <u>2/24/</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/24/</u> , 19 <u>59</u> , and that death occurred at <u>5:35 P</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>2/24/59</u>			
ACTUAL SIGNATURE <u>Stephen H. Jones</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert L. Snowden</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>	
22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>FEB 27 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> <u>M</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10.17882.561

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2163

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02147

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>43 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>922 Dashiell Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Cornelius WATSON</u>				4. DATE OF DEATH Month Day Year <u>February 10 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-90</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William WATSON</u>				14. MOTHER'S MAIDEN NAME <u>Margaret HANNON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>(W) Mrs. Margaret Watson, same as #2 above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Benign prostatic carcinoma with</u> <u>metastases</u> DUE TO (b) <u>metastases</u> DUE TO (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December 29, 19 58</u> , to <u>February 10, 19 59</u> , that I last saw the deceased alive on <u>February 10, 19 59</u> , and that death occurred at <u>11:22A</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Douglas R. Koth</u> M.D.				ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, NNMC</u>			
DATE SIGNED <u>2-11-59</u>							
PHYSICIAN'S NAME (Type) <u>Douglas R. KOTH, LT, MC, USN</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS FUNERAL HOME, 517 11th St. SE, Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

2164

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 20 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Wheaton d. STREET ADDRESS 11510 Highview Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Richard WEBB		4. DATE OF DEATH Month Day Year February 2 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-84
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Broker		10b. KIND OF BUSINESS OR INDUSTRY Merchandising	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick R. Webb		14. MOTHER'S MAIDEN NAME Jennie Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 106-05-6178	
17. INFORMANT (S) John J. WEBB, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Amphotrophic Latent Schistos DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 13, 1959 , to February 2, 1959 , that I last saw the deceased alive on February 2, 1959 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. G. Muth		DATE SIGNED 2-2-59	
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		ADDRESS (Street, city or town, state) Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 2-3-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Mr. Olivet	22d. LOCATION (City, town, or county) (State) Buffalo New York
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES CO.		ADDRESS 2901 14th St. NW, Washington, DC	
24a. REC'D BY REGISTRAR FEB 3 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

FILE NO. 10-1-1

DATE OF DEATH
1911

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

02148

2012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeoma Park</u>		c. LENGTH OF STAY IN lb <u>15 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Meyer</u> Middle <u>Efraim</u> Last <u>Weiner</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>19</u> - Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morton Weiner</u>		14. MOTHER'S MAIDEN NAME <u>Pearl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>599-322813</u>	
17. INFORMANT <u>Washington Sanitarium Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 hrs</u> <u>70 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>53</u> , to <u>Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb-19</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		ADDRESS (Street, city or town, state) <u>8641-Colesville Road</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN</u>		DATE SIGNED <u>2-19-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geowash Memorial Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217 9th NW D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2013

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF JURY		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF BURIAL		18. SIGNATURE OF CREMATION		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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2013

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02149

2165

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u> <u>Clarksburg</u> #2 <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Clarksburg</u> #2 <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Thomas</u> Middle <u>White</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27-1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Board</u>	
11. BIRTHPLACE (State or foreign country) <u>Spartanburg, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James A. White</u>		14. MOTHER'S MAIDEN NAME <u>Georganna Nealy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Frances E. White. Boyd's #2 Rd.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Cancer</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma testis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>7/20/</u> <u>19 59</u> , to <u>2/21/</u> <u>19 59</u> , that I last saw the deceased alive on <u>2/18</u> <u>19 59</u> , and that death occurred at <u>9:00</u> <u>A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>2/21/59</u>			
ACTUAL SIGNATURE <u>J.M. Bird</u>		M.D. <u>Sandy Sp</u>	
PHYSICIAN'S NAME (Type) <u>J.M. Bird</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church</u> <u>Clarksburg, Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Clarksburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Galtner</u>		24a. REC'D BY REGISTRAR <u>FEB 25 59</u>	
ADDRESS <u>Garthburg</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Galtner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02150

2017

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Wayne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN 1b 9 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wayne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut Lodge San.		d. STREET ADDRESS 321 S. County Line Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Elisabeth R. Whitmore		4. DATE OF DEATH Month Feb. Day 12 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/33
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dr. Jay B. Rudolph	
14. MOTHER'S MAIDEN NAME Edith Rondinella		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Sanatorium Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self by neck with stockings as a rope	
20c. TIME OF INJURY Month, Day, Year 10/15/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) San.	20f. (City or town) (County) (State) Rockville Montg. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/12/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	22b. DATE THEREOF 2/14/59	22c. NAME OF CEMETERY OR CREMATORY South Laurel Hill	22d. LOCATION (City, town, or county) (State) Philadelphia Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR FEB 18 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2166

CERTIFICATE OF DEATH

Reg. Dist. No.

02151

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3211 Thornapple Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Mansur Last Wight				4. DATE OF DEATH Month Feb. Day 23 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/1863	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maine	
13. FATHER'S NAME Morriall Mansur				14. MOTHER'S MAIDEN NAME Iantha Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mildred W. Syfrig				Address 3211 Thornapple St. Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Chronic congestive Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) advanced age DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sub-acute bronchitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 19 55 to Feb 23 19 59 , that I last saw the deceased alive on Feb 23 19 59 , and that death occurred at 8:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John V. Dolan				ADDRESS (Street, city or town, state) 3100 Conn ave			
PHYSICIAN'S NAME (Type) John V. Dolan				DATE SIGNED 2/23/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley H. Niles Co.				ADDRESS 2901 14th St. NW D.C.		24a. REC'D BY REGISTRAR DATE FEB 25 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Thomas			

CERTIFICATE OF DEATH

Reg. Dist. No.

02152

2013

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C. Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Isakoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>			
c. LENGTH OF STAY IN 1b <i>1 yr. 2 mo.</i>				d. STREET ADDRESS <i>4220 Van Ness St., N.W.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <i>OAK HAVEN REST HOME</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Della Hoover Wilber</i>				4. DATE OF DEATH Month Day Year <i>Feb - 15 19 59</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 18, 1869</i>	
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Staunton, Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
13. FATHER'S NAME <i>William Hoover</i>				14. MOTHER'S MAIDEN NAME <i>Mary Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Inez Edith Wilber M.D.</i> Address <i>4150 Van Ness St. N.W.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO <i>470x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>pneumonia hypertatic</i> DUE TO (c) <i>Repeated colds</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Advanced age</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Dec 30, 1958</i> , to <i>2-15, 1959</i> , that I last saw the deceased alive on <i>2-13, 1959</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Louis K. Alpert</i> M.D.				ADDRESS (Street, city or town, state) <i>2300 K St. N.W. Washington, D.C.</i> DATE SIGNED <i>2/15/59</i>			
PHYSICIAN'S NAME (Type) <i>Louis K. Alpert</i>				22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			
22b. DATE THEREOF <i>2/16/59</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			
22d. LOCATION (City, town, or county) <i>Suitland Md.</i>				23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas Chase Funeral Home</i> ADDRESS <i>302 W. Wisconsin Ave. Washington, D.C.</i>			
24a. REC'D BY REGISTRAR <i>Feb 18 '59</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02153

2014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>61 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant Boy</u> First Middle Last <u>Wilson</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-59</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Reynolds Wilson, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Shanks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>mother's Chart</u>			
17. INFORMANT Address <u>mother's Chart</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour & 1 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Valgene M. Milstead, M.D.</u>				ADDRESS (Street, city or town, state) <u>925 Pershing Dr., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Valgene M. Milstead, M.D.</u>				DATE SIGNED <u>2/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>				ADDRESS <u>Washington Sanitarium and Hosp., Takoma Park, Md.</u>			
24a. REC'D BY REGISTRAR <u>FEB 11 1959</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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CERTIFICATE OF DEATH

1914

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WALKER BROWN

WALKER BROWN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G238 2-11-59 et
Item 18 Film 241 4-22-59 ams

CERTIFICATE OF DEATH

02154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ann Wilson</u>				4. DATE OF DEATH Month Day Year <u>February 1 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1941</u>	
9. AGE (In years last birthday) yrs. <u>17</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Moses F. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Twyman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mary Ann Wilson (mother) Gaithersburg, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema & Atelectasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>681x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Streptococcus Veridans Septicemia</u> DUE TO (c) <u>Acute Streptococcal Endometritis (puerperal)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 29, 1959</u> to <u>FEB 1, 1959</u> , that I last saw the deceased alive on <u>FEB 1, 1959</u> , and that death occurred at <u>1215</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 WILSONS AVE, BETHESDA, MD</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Thomas M. Wilson</u>				PHYSICIAN'S NAME (Type) <u>THOMAS M. WILSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/5/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

and ON THE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED		19. SIGNATURE OF NEXT OF KIN		20. SIGNATURE OF OTHERS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2168

CERTIFICATE OF DEATH

Reg. Dist. No.

02155

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS R.F.D. # 1	
3. NAME OF DECEASED (Type or print) Margaret Elizabeth Woodfield		4. DATE OF DEATH Month February Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1940
9. AGE (In years last birthday) yrs. 18		10. IF UNDER 1 YEAR: Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John G. Woodfield		14. MOTHER'S MAIDEN NAME Elizabeth Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal hemorrhage 705.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Systemic Lupus Erythematosus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 27, 19 59 , to February 25 19 59 , that I last saw the deceased alive on February 25, 19 59 , and that death occurred at 12:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-25-59 ACTUAL SIGNATURE Charles F. Brooks M.D. The Clinical Center PHYSICIAN'S NAME (Type) Charles F. Brooks, MD National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Moleworth		24a. REC'D BY REGISTRAR MAR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1900</u></p>	
<p>5. Place of birth: <u>London, England</u></p>		<p>6. Date of death: <u>Dec 15, 1945</u></p>	
<p>7. Cause of death: <u>Myocardial infarction</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. Smith</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Dec 16, 1945</u></p>		<p>12. File number: <u>100-12345</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2169

CERTIFICATE OF DEATH

Reg. Dist. No.

02156

1. PLACE OF DEATH a. COUNTY MARYLAND Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b 17 yrs. 8 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg d. STREET ADDRESS 13x-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma Virginia Wright		4. DATE OF DEATH Month February Day 28 Year 1959		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH July 21, 1870 9. AGE (In years last birthday) 88 yrs IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Howard Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Albert Wright		14. MOTHER'S MAIDEN NAME Margaret Almira Stansfield					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 8-7 , 1957 , to 2-28 , 1959 , that I last saw the deceased alive on 2-28 , 1959 , and that death occurred at 9:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 CEDAR LANE KENSINGTON, MD		DATE SIGNED 2-28-59			
PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-59		22c. NAME OF CEMETERY OR CREMATORY Mt. View			
22d. LOCATION (City, town, or county) (State) Glenelg, Howard Md.		23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.					
24a. REC'D BY REGISTRAR MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. France					

CERTIFICATE OF DEATH

2182

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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Myocardial infarction

11/1/58

2-28 8-1

2-28

10128 Cedar Lane
Kensington, MA

James E. Glover

James E. Glover

2-28